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Experiences of BSN Graduates Integrating Cultural Competence when Caring for Multicultural Patients

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Registered nurses entering the workforce with baccalaureate of science degrees in nursing (BSN) are expected to be knowledgeable and skilled in planning and caring for multicultural patients, but there is little information on what experiences new nurses have in implementing culturally competent care. The purpose of this descriptive phenomenological study, guided by the Campinha-Bacote process of cultural competence in the delivery of health care services model, was to understand the lived experiences of BSN graduates with one year or less experience in implementing cultural competence in planning care for their multicultural patients. The research question directly addressed this purpose. Ten participants were interviewed using one-on-one, open-ended interviews. Coding and thematic analysis was conducted using Colaizzi's process to analyze and interpret the data. Key findings were that BSN nurses practicing one year or less had (a) multidimensional views of cultural competence, (b) acquired cultural knowledge through experience, (c) believed open communication was essential to implementing cultural competence, and that (d) cultural accommodation was provided through advocacy. Thus, the nurses were able to use methods that over time increased their awareness, knowledge, skill, desire, and encounters of cultural competence. The results of this study can be used to inform academic institutions and health care organizations to ensure clinical experiences that develop cultural competence prior to graduation. Improving cultural competence among new graduates can prevent inequities in health care and support patient safety, supporting positive social change.

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Dedication

This degree is dedicated to my mom, who has been with me, supported me in all my highs and lows. My two sons Jason and Jori who realize what it means to be persistent. My family and friends who have helped to make it happen. Most of all I thank God for answering my prayers.

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Chapter 1: Introduction to the Study

In the current clinical environment, it is not unusual to care for individuals from different cultural backgrounds. Knowing how to relate, be sensitive, and have a knowledge of a particular culture, its beliefs, values, and practices are a necessity for nurses entering professional practice (Smith, 2017). The expectation is that baccalaureate of science in nursing (BSN) graduates are culturally competent to provide culturally competent care to a multicultural population. Culturally competent care is the ability to provide equitable care while considering the cultural background of the patient and incorporating it in the care of the individual (Campinha-Bacote, 2002; Papadopoulos, 2006). Cultural competence is essential to the provision of quality patient care. Culturally competent care reduces cultural inequalities in the care provided, improves patient outcomes, establishes trust between patient and practitioner, and promotes compliance. The practitioner also is impacted by improved knowledge in caring for a diverse population and improved cultural awareness.

The Institute of Medicine (IOM; 2008) recognized cultural competence as an essential skillset for all health care professionals, primarily those interacting with individuals from diverse cultures. Although this was the mandate by the governing bodies of nursing, such as the National League of Nursing or ACCN, there are no standardized methods of educational application. Therefore, it was left to each school of nursing to either integrate cultural competence into their present curriculum, develop stand-alone courses, or provide immersive study experiences. No one method has shown to be more

acceptable or superior; however, the literature identified immersive studies as the method with the best graduate outcome (Amerson, 2010; Chen et al., 2012; Gower, 2019).

In addition to the lack of standard methods for teaching cultural competence, what is not known is the lived experience of the BSN graduate in integrating cultural competence in planning care for a multicultural population. Although numerous studies have investigated the levels of cultural competence of BSN nurses (Mareno & Hart, 2014; Parker et al., 2014; Repo et al., 2017), there are no studies on how BSN graduates with 1 year or less in practice integrate cultural competence in planning or providing care to a multicultural population. This study's focus is directed at the lived experiences of this cohort to understand their interpretation of cultural competence. This study determined how BSN graduates have integrated cultural competence in planning care for their multicultural patients.

Background of the Study

Intro to cultural competent care, cultural competence emerged as a framework for addressing diversity and inequality in the United States in the 1980s (Campinha-Bacote, 1994). Cultural competence can be defined as recognizing the importance of culture and being aware of cultural differences, adapting services to meet cultural needs (Betancourt et al., 2002, p. 118). Campinha-Bacote's (2007) model of cultural competence emphasizes the ability to integrate the components of cultural knowledge, cultural skill, cultural awareness, cultural desire, and cultural encounters. The provision of culturally competent care by nurses is thought to improve the outcomes and patient satisfaction and enhance providers' knowledge and skills. Therefore, caring for a multicultural population

in a culturally competent manner is a standard of care that is expected of BSN graduates and all other health care providers (Mesler, 2014). Previous quantitative nursing research studies concluded that nursing students demonstrate a moderate amount of knowledge and skills regarding cultural competence (Mesler, 2014; Silvestri-Elmore, 2017; Gower et al., 2019).

Methods for education on cultural competence. The National League of Nursing (2008) and the American Association of Colleges of Nursing (AACN; 2009) recognized the need to include culturally competent content across the nursing curriculum but did not specify how this should be done. The method of delivery was left to the schools of nursing. Therefore, there is no standard method for the delivery of content on cultural competence. The most frequently studied methods used to integrate cultural competence into the nursing curriculum are stand-alone courses, integration into the curriculum, and immersive opportunities.

- Stand-alone courses in cultural competence is a single course in cultural competence that is independent of all other courses in the nursing curriculum and is completed in a set number of weeks. A final grade is assigned at the end of the course.
- The integration of cultural competence in the nursing curriculum involves applying culturally competent content throughout the curriculum without any specific design. For example, when teaching about a particular disease, the culture of patients who are prone to this particular disease would be discussed

(e.g., diabetes and Latino individuals, hypertension and African American individuals).

- Immersive opportunities include learning locally or internationally in communities of different cultures, languages, and customs. This allows students to learn about the culture face-to-face by interacting with the people and understanding the values, language, customs, perception of health, and lifestyles.

Studies addressing need to understand whether graduates are culturally competent. Because of the lack of standards for teaching cultural competence, there is a need to understand whether BSN graduates are prepared to provide culturally competent care, which several studies have highlighted. For example, Repo et al. (2017) evaluated the level of cultural competence of graduating students in Southern Finland within a multicultural population and found that the majority of the participants were culturally aware, with the remaining being culturally safe. Further, though literature has suggested that teaching cultural competence in nursing has resulted in positive learning outcomes (Chen et al., 2018; Long, 2012; Mareno & Hart, 2014), Repo et al. found no significant differences in cultural competence between students who had studied multicultural nursing compared to those who did not. In another study on different curricular processes for teaching cultural competency content (service-learning projects, cultural immersion abroad, cultural immersion within other cultures at home, free-standing cultural courses, and integration into the curriculum), the results suggested that older, more experienced students with second degrees were not culturally knowledgeable but were culturally

aware (Kardong-Edgren et al., 2010). Similarly, Knecht and Fischer (2015) found that service-learning improved undergraduate nursing students' reflection on upbringing, empathy, and advocacy. Further, Creech et al. (2017) conducted a pre- and post-intervention study and determined that cultural competence in graduate nursing education could be improved.

Relevance of study: Most studies have been designed to examine the socialization of the new roles developed during the first year of practice. But there is a need for further research on the incorporation of cultural competence in planning care for the care of a population of multicultural patients. Little is known about the BSN graduates who are now 1 year or less in professional practice and how cultural competence is integrated into their plan of care for their patients (Chen et al., 2018). Therefore, I investigated BSN graduates' cultural competence and how it is applied in their practice. For this study, the Campinha-Bacote framework was used to measure cultural competence, as there remains a lack of tools to comprehensively measure cultural competency among practicing nurses.

Problem Statement

BSN graduates are expected to provide culturally appropriate care to individuals who are not of the same culture. The IOM, National League of Nursing, and the AACN have recognized the importance of the provision of culturally competent care, mandating that culturally competent content is added to all nursing curriculum to decrease inequities among multicultural populations and also improve health care outcomes (The Joint Commission of Accreditation of Healthcare Organizations, 2010). But some studies have indicated that nursing education curricula be examined to determine the effectiveness of

academic preparation and the lack of consensus on how to provide culturally competent care (Curtis et al., 2016).

Levels of cultural competence among BSN nursing graduates have been studied (Cruz et al., 2016), and studies have shown that graduate nurses are moderately competent in cultural competence (Mareno & Hart, 2014; Mesler, 2014; Repo et al., 2017). However, their ability to display and practice cultural competence in attitudes and behaviors while transitioning to the practice role within multicultural health care systems is not known (Shatell et al., 2013). Studies examining levels of cultural competence have yielded only one consistent finding: that training or education on cultural competence supports a level of cultural awareness among practicing nurses (Cruz et al., 2018; Repo et al., 2017). All health care providers have a responsibility to provide an environment that recognizes and accepts differences without discrimination (American Nursing Association, 1998). Providers should be aware of dominant cultural groups in their communities to better understand how to care for them. But little is known about the perception of the BSN graduates in providing culturally competent care. Thus, this study was needed to gain an understanding of the perceptions and experiences BSN prepared newly graduated nurses regarding how they implemented culturally congruent care in their practice, providing baseline evidence of the method of educational preparation of cultural competence in BSN programs.

Purpose of the Study

The purpose of this study was to understand the lived experiences of BSN graduates with 1 year or less in practice as they integrate cultural competence in planning

care for their multicultural patients. The choice of this particular cohort was to obtain data at the beginning of the nursing careers while having just graduated, meaning the academic preparation is recent. The essence and meaning of the experience of each person was sought through descriptive phenomenology to fill the gap in the literature and answered the overarching research question.

Research Question

What are the lived experiences of recent BSN graduates (1 year or less into practice) of integrating cultural competence into planning care for a multicultural population?

Theoretical Framework

The theoretical basis for this study was Campinha-Bacote's (2002) cultural competence model. The model posits that the process of cultural competence in providing health care services is the ability to demonstrate cultural awareness by individuals examining their cultural background, biases, and prejudices. The process of cultural competence in the delivery of health care services (PCCDHS) model is more comprehensive than other theoretical frameworks because of its five constructs: cultural knowledge, cultural skill, cultural awareness, cultural desire, and cultural encounters. Cultural knowledge is obtaining a broad knowledge base of diverse cultures and populations. Cultural skills involve collecting relevant cultural data and using the data to perform culturally based assessments. Cultural desire involves seeking opportunities to care for and interact with a multicultural population. Another important aspect of this model is the emphasis on the cultural assessment for every individual patient because

every patient is unique in their values, beliefs, and practices that must be considered when planning or providing care (Campinha-Bacote, 2010). The last component of the model, cultural encounters, posits the need for face-to-face interactions with individuals of diverse cultural backgrounds on a local or international level (Eche & Aronowitz, 2017).

Campinha-Bacote's model has been widely used in research to determine cultural competence (Abitz, 2016; Almutairi et al., 2015; Kardong-Edgren, 2007, 2010; Mareno & Hart, 2014). Campinha-Bacote's model of cultural competence is the most comprehensive of all transcultural models, meeting all criteria in building on each of the constructs, which is logical in progression in providing concise outcomes for interventions while providing a clear description of the process (Brathwaite, 2005). This allows for an immediate clinical benefit in enhancing patient care planning. Finally, Campinha-Bacote's model recognizes the importance of experiences in shaping and advancing cultural competence in individuals. This lifelong process or journey is based on becoming culturally competent. The model's five constructs were used to guide the discussion of the findings of this study. More detail on Campinha-Bacote's cultural competence model will be presented in Chapter 2.

Nature of the Study

The study involved a qualitative phenomenological approach using a descriptive design. Phenomenology is designed to elicit the lived experiences of individuals in a rich description of their experiences (Georgi, 2009), while using epoche or bracketing (Knecht & Fischer, 2015) to set biases aside, which this leads to new ways of

experiencing the phenomenon. Thorough transcendental reduction, the self is free to discover the phenomenon (Knecht & Fischer, 2015). The multiple realities and subjective beliefs are mentally constructed by the individual (Polit & Beck, 2008). The researcher explores the participant's reality without a fixed agenda while maintaining scientific rigor throughout the process (Rudestam & Newton, 2015).

The key phenomenon in this study is the BSN graduate with 1 year or less in practice and the integration of cultural competence in planning the care of a multicultural population. The study follows a qualitative research approach involving the use of semi-structured interviews as the primary means of data collection. The data analysis was done simultaneously with data collection. The use of open coding helped in the development of themes or categories. Epoche was used to minimize prejudices or assumptions regarding the phenomenon being studied (Merriam, 2009).

Definitions

The following definitions are relevant to the concepts presented in the study. Terms defined here have multiple meanings. However, the definitions used in this study serve to reduce any misconceptions that may arise.

Cultural competency: A continuous process in which the nurse or health care provider strives to work within the cultural context of an individual, family, or community from a diverse cultural background (Campinha-Bacote, 1994).

Culturally congruent care: The use of sensitive, creative, and meaningful care practices to fit with the general values, beliefs, and lifeways of individuals for beneficial

and satisfying health care, or to help them with difficult life situations, disabilities, or death (Leininger & McFarland, 2002).

Culture: "Shaped by values, beliefs, norms, and practices that are shared by members of a cultural group" (Giger & Davidhizer, 2008, p. 2).

Ethnicity: "A group whose members share a common social and cultural heritage passed on to each successive generation" (Giger & Davidhizer, 2008, p. 71).

Ethnocentrism: The tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways" (Purnell & Paulanka, 2008, p. 6).

Multiculturalism: A belief that many different cultures exist in the world and that this diversity should be understood and valued (Leininger & McFarland, 2002).

Transcultural: "Across all world cultures whether a nation or not" (McDonald, 2008, p. 35).

Transcultural nursing: A formal area of study and practice focused on comparative human care differences and similarities of the beliefs, values, and patterned Lifeways of cultures to provide culturally congruent, meaningful, and beneficial health care to people (Leininger & McFarland, 2002, p. 6).

Assumptions

The major assumption of this study was that BSN graduates provided an open and honest response to this researcher and not what is expected. I made every effort to establish trust prior to interviewing each volunteer participant, as honesty is a component of trust (Mayer et al., 1995). I also assumed that BSN graduates desire to be culturally

competent in care to individuals from a multicultural background. I further assumed that students receive training on cultural competence during enrollment in their respective nursing program. Learning and knowledge regarding cultural competence should have been assessed by the educational institution during enrollment, indicating that they are equipped to implement culturally competent practices.

Scope and Delimitations

The scope of this study was inclusive of only BSN graduates practicing 1 year or less in the healthcare environment in the Northeast, Southeast, West, and Midwest United States. This study did not consider nurses from associate programs, masters programs, or nurses who have been practicing for over 1 year. BSN graduates are given a more theoretical basis for the concepts taught and are the minimum standard recommended for entry into practice.

I considered several models before determining that Campinha-Bacote's PCCDHS model was the most appropriate to frame this study (Campinha-Bacote, 1998). The first model considered was Madeline Leininger's (1970) culture care and universality theory. Twenty years ago, racial disparities were a common and noticeable phenomenon (IOM, 2010). Madeline Leininger developed her theory in hopes that nursing would help to eliminate disparities by becoming knowledgeable in the beliefs, values, and lifeways of individuals from different cultures and incorporating them into their plan of care. Campinha-Bacote (1999) went a step further and built on Leininger's theory by identifying a model that has the components necessary for becoming culturally competent.

The next model that was considered is Papadopoulos et al.'s (1998) model, which is similar to Campinha-Bacote's but adds cultural sensitivity to reflect the importance of interpersonal relationships and perceptions of the care delivered by health care providers. Effective transcultural communication must take place to achieve cultural sensitivity. Transcultural communication requires the nurse to learn how to understand the cultural values, behavioral patterns, and the rules of interaction for the specific culture and to recognize the challenges of communication across cultural boundaries, such as lack of interpreters for patients who speak a different language. According to Papadopoulos et al., much of the research using this model has focused on interpersonal relationships among healthcare providers from different cultures. Thus, this model was not chosen due to the extensive application of Campinha-Bacote's model in the area of nursing education, nursing research, and the fact that it is inclusive of all the variables or constructs in the Papadopoulos model.

The next model considered was Purnell's (2005) model of cultural competence. Like Campinha-Bacote (2002), Purnell posited cultural competence as a process, not an endpoint. Purnell's model is characterized by four levels of increasing cultural competency. The model is frequently used as a framework for providing cultural education and has been used to evaluate cultural competence in clinical and academic settings American Nurses Credentialing Center (ANCC, 2008). The Purnell model was not chosen because it did not fit the aim of my study in understanding the experiences of recent graduate nurses who have 1 year or less in practice.

The final model considered was that of Giger and Davidhizar (2002), who developed the transcultural assessment model to assist nursing students in undergraduate programs to assess and provide care to individuals from diverse cultures. This model consists of six constructs representing cultural phenomena. Similar to Leininger's transcultural nursing theory, Giger and Davidhizar's (2008) model supports nursing care that is reflective of the patient's cultural identity as an individual influenced by ethnicity, culture, and religion. Furthermore, patients are conceptualized as equal partners in the assessment and planning of their care with the provider taking the patient's values, beliefs, and worldview into consideration when providing care. This model was not chosen because it focused on describing the process of cultural interactions rather than the process of becoming culturally competent. A model that explains how cultural competence is developed supported an understanding of how nurses perceive the role of education and experience in their ability to practice culturally competent care.

Transferability was enhanced by the use of a rich thick description of the participants' experiences. A detailed description of the setting and participants, as well as evidence presented from participant's quotes, and field notes, was documented so that similarities can be made between the participants and the study in future research (Merriam, 2009).

Limitations

The potential limitations of this study are the challenges of recruiting using advertising in social media or word of mouth, which may not generate interest. This may have led to a slow response rate or hinder recent graduates' willingness to participate.

Time restraints, in terms of getting nurses to commit to a 1-hour interview, and limited compensation of $10 (a thank you), may have not led to robust participation. Hence, recruitment was achieved through social media and snowball sampling. The use of a qualitative design does not limit my ability to transfer the findings because the data was more inclusive of different regions of the United States. Although the sample may be small, the provision of sufficient descriptive data was enough to make transferability possible. To mitigate any biases, I used bracketing to control any of my personal bias that might influence the interview or participant participation in the study.

Significance

The population of the United States is expected to increase by 2050, and minorities are expected to constitute 54% of the population (U.S. Census Bureau, 2010). Graduates of many BSN programs will encounter diversity in a myriad of ways, not just race or gender (Cuellar, 2016). Encounters with individuals from diverse cultural backgrounds do not automatically ensure cultural competence (Kumas-Tan et al., 2007); culturally competent care refers to the quality of the communication such as affirmations and empowering responses rather than stereotypical and marginalized responses. But evidence indicates that health care provider bias, stereotyping, and prejudice contributes to health care disparities due to cultural differences, lack of access to care, poverty, and poor health literacy, which contributes to poor health outcomes (Aponte, 2012; Mareno & Hart, 2014). However, when health professionals engage in culturally competent practices, they enjoy improved relationships with their patients, and their patients reap important health benefits through improved quality and equity in health care (Saha et al.,

2013). Thus, improving cultural competence among providers, including nurses, may reduce racial/ethnic disparities in health outcomes. Ongoing education is important to increase the level of cultural competence in providing care to a multicultural population (Almutari et al., 2017).

The IOM has suggested the best way to eliminate health care disparities is by incorporating cross-cultural education and culturally competent practice into the nursing education curricula (Shatell et al., 2013). The AACN has also endorsed the addition of content addressing cultural competence to nursing curricula as a strategy towards the elimination of healthcare disparities. The goal is to develop nursing graduates who demonstrate the cultural attitudes, knowledge, and skills necessary for providing appropriate care to a diverse or multicultural population (Shatell et al., 2013). This study is thus significant to social change because understanding the lived experiences of the BSN graduate nurses with 1 year or less in practice who must integrate academic knowledge of clinical practice and cultural competence during their interactions with patients can direct changes to policies, procedures, and education.

Additionally, various self-reporting measures have been applied to detect the level of cultural competence among graduate nurses but increases in cultural awareness are the only detectable outcome of having received training in cultural competence (Cruz et al., 2018; Lampley et al., 2008; Repo et al., 2017). Thus, there is a need to examine the benefits of cultural competence education to nursing practice with greater depth. Few studies of BSN graduates used a qualitative approach when studying cultural competence among nurses. This systematic approach allows the participant to articulate the core of

their experience that can be explored to better understand how they perceive their educational preparation and practice of cultural competence. For example, Salisman et al. (2018) recently examined cultural integration through the lived experiences of ESL students in online registered nurse (RN) BSN programs. The use of phenomenological reflection in the current study allowed insights into their personal challenges and triumphs with integration, writing, and obtaining support for success. Findings of this study can be shared to create a dialogue regarding cultural competence and the recent graduate.

Summary

In summary, caring for a multicultural population in a culturally competent manner is a standard of care that is expected of graduates and all health care providers. Changes to the U.S. demographic and cultural makeup demands that nurses are competent in providing culturally competent care to a multicultural population. Although previous studies concluded that nursing students demonstrate a moderate amount of cultural competence in their perception of their abilities via quantitative methods, no qualitative studies have been done with this cohort of nurses. Therefore, this study fills that gap. In Chapter 2, I present a literature review of cultural competence as it relates to nursing educational preparation, implementation of cultural competence, and outcomes of BSN graduates.

Chapter 2: Literature Review

The U.S. Census Bureau reported that minority populations have grown significantly, and this trend will continue in the coming decades (LaVeist & Isaac, 2013). These changes have led to diversity not only in culture but in attitudes, beliefs, and various circumstances that impact health status (Silvestri-Elmore et al., 2017). As a result, the expectation of new nursing graduates is the ability to provide culturally competent care to a diverse population (Kajander-Unkuri et al., 2014; Repo et al., 2017). BSN graduates are expected to have a high level of cultural competence due to the emphasis of the AACN (2011) mandate to educate nurses to care for patients across the lifespan, which can improve patient care quality (Mareno & Hart, 2014; Mesler, 2014). But the transition into professional practice for a new graduate 1 year into practice is challenging in terms of socialization in a new environment, orientation, and applying principles learned from their curriculum (Beecroft et al., 2008; Kajander-Unkuri et al., 2014; Parker et al., 2012).

The literature contains information on the level of cultural competence of student nurses, graduate nurses, and practicing nurses (Chen et al., 2018; Liu et al., 2018). The literature has identified that culturally competent care is lacking in face-to-face interactions with individuals from diverse cultures. However, there are no supporting studies of a qualitative design that would identify the lived experiences of the BSN graduate practicing 1 year or less. Therefore, an investigation is necessary for the perceptions and lived experiences of this cohort. This gap in the literature regarding this cohort of nurses and their experiences when caring for a multicultural population needs to

be investigated. The purpose of this study was to understand the lived experiences of BSN graduates with 1 year or less in practice as they integrate cultural competence in planning care for their multicultural patients.

In Chapter 2, I will present the search strategy I used to explore the literature, theoretical framework, definition of terms, and a synthesis of the literature. I will address several major topics, including a historical progression of cultural competence to establish a foundation, cultural competency in nursing education, cultural competence in nursing, measurement tools of cultural competency. I conclude the chapter with a summary.

Literature Search Strategy

The search for primary research regarding the cultural competence of nursing graduates required the use of numerous terms. There are several terms associated with cultural competence; therefore, cultural competence encompassed the words *transcultural* and *diversity* because they are reflective in determining cultural competence. *Cultural humility* and *cultural awareness* were added as some studies used these terms alternatively. These are other keywords I used in my search: *cultural competence, diversity, cultural awareness, cultural humility, cultural competence of BSN graduates, BSN nursing programs, cultural competence in nursing education,* and *nurse transition to practice*.

When I added the search term *BSN graduate*, and the search produced 13,200 results. When I added the term, *BSN graduates and one year or less in practice*, I received no results. Therefore, I concentrated on the education, training, and the use of

the Campinha-Bacote framework, the process of cultural competence in the delivery of healthcare services (1998a), which is relevant to the topic and research question. Many keyword combinations returned zero results as no studies have been done in the context of cultural competence in conjunction with the BSN graduate after graduation. The majority of the studies were found in the area of education and training.

I searched major databases in the field of nursing education and psychology, such as EBSCO and Ovid, which looked at behaviors and evaluation tools of cultural competence. Six electronic databases were searched, ERIC, EBSCO, Ovid, ProQuest, CINAHL, and an internet search using Google Scholar covering 2010–2019 to obtain the current state of this concept. All included studies had to be peer-reviewed articles, or scholarly books, white papers, regulatory mandates, or position papers. Of the articles retrieved, most were excluded after the abstract and article review process, leaving articles that were relevant to the study. Articles pertaining to undergraduate level, including BSN and associate degree graduates, were added for contrast. The articles on educational preparation were included because they provided evidence of various interventions used to provide cultural competence training for future nurses. These various methods of instruction included stand-alone courses, integration into the curriculum, or service-learning/immersive experiences. Moreover, not all research studies found were included in this study. Studies greater than 10 years old were excluded unless they had historical significance. Also excluded were non-nursing studies such as business or other disciplines.

Theoretical Framework

The framework guiding this research is the PCCDHS model by Campinha-Bacote's (2002), which describes the process of becoming culturally competent practitioners. In 1991 Campinha-Bacote conceptualized the model as a result of the changing demographics and economics that led to disparities in health care and the status of people from diverse cultures and ethnic backgrounds in the United States (Campinha-Bacote, 2002). The model views cultural competence as a framework for health care providers to use in developing and implementing culturally responsive health care services. The model posits that providers should perceive themselves as becoming culturally competent rather than already being culturally competent. The first version of the model identified four constructs of cultural competence: cultural awareness, cultural knowledge, cultural skill, and cultural encounters. In 1998, the model was expanded to include the concept of cultural desire as the key to becoming culturally competent and focused on the transcultural aspects of healthcare. Later, the Inventory Assessing the Process for Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) was developed to measure cultural competence. According to Campinha-Bacote (2010), the research that emerged from the use of the IAPCC-R indicated that cultural encounters were pivotal to the process of becoming culturally competent.

Propositions and Assumptions

Campinha-Bacote (2002) defined cultural competence as "the development of an ongoing process that includes cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire" (p. 202). According to Campinha-Bacote,

cultural competence is not a goal or destination one can ever achieve but is a journey that must be continued across the lifespan. This journey across this continuum includes commitment, conceptual and experiential learning, self-reflexivity, motivation, and discipline. The process of obtaining cultural competence is dynamic and involves ongoing work with individuals, families, and communities of diverse cultural backgrounds. Thus, becoming a culturally competent provider is an intentional process that involves a willingness to seek opportunities to explore and interact with different cultures.

The model also assumes that there is a direct relationship between the level of cultural competence of health care providers and their ability to provide effective, culturally responsive health care services. The model posits that there is more variation within ethnic groups than across ethnic groups (Campinha-Bacote, 2002). Thus, acknowledging that individuals from the same ethnic group can exhibit practices and behaviors not necessarily shared by that group. For example, the Haitian culture generally ascribes to a strong belief in Voodoo (Desrosiers & Fleurose, 2002), but certain individuals within that culture may reject that belief entirely.

Further, Campinha-Bacote's (2002) process model is characterized by five interdependent constructs that occur simultaneously: cultural awareness, cultural knowledge, cultural skill, cultural desire, and cultural encounters. To fully understand the model, each construct will be defined and discussed in the following sections.

Cultural Awareness

Cultural awareness is the ability of the caregiver to demonstrate personal awareness of their own culture while being able to interact with individuals of another culture and incorporate these attributes into their practice (Campinha-Bacote, 1999). Conflicts with cultural beliefs and practices can interfere with individuals who are outside of that culture. Being culturally aware impacts the interactions of care, communication, treatment, and perceptions. However, the tendency is for individuals to use their culture as a benchmark to categorize or judge others. This display of ethnocentrism is evident in the makeup of the nursing hierarchy, which is predominantly White and middle class, with others in the minority. This first step to accepting diversity is awareness and acknowledgment of the different cultures, values, beliefs, practices, and lifeways.

Cultural Knowledge

Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups (Campinha-Bacote, 2002). Cultural knowledge is dependent on several factors: development of self-awareness (the way one's culture has influenced one's identity or makeup, and worldview), being able to comprehend from others' perspectives a multicultural world. To achieve cultural knowledge, the health care provider must understand the worldview of the patient (Campinha-Bacote, 2007, p. 37). This stage provides an individual the opportunity to leave his or her own perspective and move into the patient's perspective.

Cultural Skill

Cultural skill is dedicated to the implementation of cultural knowledge by observing, listening, evaluating, analyzing, interpreting, relating, and communicating. Cultural skill is the ability to gather necessary cultural data that pertains to the patient's health problem and performing a culturally-based assessment. The health care provider should be aware of how the patient's physical, biological, and physiological differences will affect their ability to carry out the proper and appropriate physical evaluation (Campinha-Bacote, 2007, p. 49). Cultural skill entails not using the same treatment methodology to address every patient's health concerns. Nurses who have these capabilities are able to influence outcomes that consist of flexibility, adaptability, a multicultural perspective, and empathy (Campinha-Bacote, 1999).

Cultural Encounters

Cultural encounters are interactions that are face to face, indirect, or other types of interactions with culturally diverse individuals. Communication abilities are a major component of cultural encounters for being able to understand the various cultures. Cultural encounters also help practitioners learn about and understand different multicultural groups and help to eliminate stereotypes and ethnocentrism (Campinha-Bacote, 2007). Cultural encounter is a process that encourages the health care provider to participate directly in cross-cultural interactions with clients from a culturally diverse background different from that of the provider (Campinha-Bacote, 2007, p.71). In this stage, a health care provider has the opportunity to learn from the patient and use the knowledge gained to address the patient's treatment.

Cultural Desire

Cultural desire is the motivation and desire to seek out opportunities to be exposed to different cultures to enhance one's cultural competence (Campinha-Bacote, 2007). In terms of health care experts, this means them wanting to participate in the practice of becoming culturally skilled, aware, and knowledgeable. At this stage in the model, a health care provider has picked up a subconscious desire to learn about other cultures without many directives. This stage embraces the act of caring and genuine passion for accepting cultural differences and openness to build on similarities (Campinha-Bacote, 2007, p. 21).

All five constructs are interdependent on one another; thus, the development of any of the constructs will improve the development of the others. Cultural encounter is the construct of central importance because seeking and experiencing many cultural encounters can advance the development of the other four constructs (Campinha-Bacote, 2012). Nonetheless, the development of all five constructs over time is required to become fully competent in the care of individuals from culturally diverse groups (Campinha-Bacote, 2002).

Application of the Research

A review of the literature demonstrates the focus of the theoretical applications and the methodological studies on BSN graduates having no consensus on a standardized application of how to teach culturally competent content. Campinha-Bacote's model of cultural competence, the PCCDHS, has been used to organize transcultural concepts in nursing education, for measurement of cultural competence, and has been applied to other

disciplines, internationally and globally (Kardong-Edgren & Campinha-Bacote, 2008). PCCDHS has been applied to all areas of nursing, including psychiatry, pediatrics, spirituality/ religion, and obstetrics (Alpers & Hanssen,2013). This framework has also been the foundation for the development of other models and theories (Abitz, 2016). The PCCDHS is ideal in the assessment of cultural competence in recent graduates one year or less in practice. Further, the PCCDHS has been endorsed as a model for conducting culturally sensitive research (Ackerman-Barger, 2010; Buscemi, 2011; Campinha-Bacote, 2011), clinical practice within nursing specialties (Hayward & Charette, 2012; Ingram, 2012), and health professions education (Campinha-Bacote, 1998b; Campinha-Bacote et al., 1996; Hawala-Druy & Hill, 2012; Mareno & Hart, 2014). Other applications of this model are as a guiding framework for management and administration, and health care organizations to provide culturally relevant services (Campinha-Bacote, 1999; 2003).

Rationale

The PCCDHS model by Campinha-Bacote provides a foundation to guide nursing by detailing the process of becoming a culturally competent health care professional. The model illustrates how culturally competent nurses can support a positive nurse–patient relationship while reducing healthcare disparities through the care provided. The model posits that the provision of culturally responsive care is an important component of effective healthcare services. The PCCDHS has been used extensively in nursing research (Almutairi et al., 2015; Chen et al., 2018; Hart & Mareno, 2016; Silvestri-Elmore et al., 2017) and nursing education (AACN, 2008; National League of Nursing, 2013; Kardong-Edgren et al., 2010) where it has been used to organize transcultural concepts in nursing

courses in academia and to assess cultural competence (Kratzke & Bertolo, 2013). Thus, in this study, the model was used as a lens through which to compare themes that are similar and different to the constructs of the PCCDHS during the analysis of the findings. Further, this study may build on the existing PCCDHS model by providing foundational evidence of recent graduates' perceptions regarding the relative value of cultural knowledge acquired through academic preparation and cultural knowledge that is acquired through clinical experiences in caring for multicultural populations at the community, family, and patient levels.

Literature Review Related to Key Variables and/or Concepts

The influence of a global migration on the population is apparent in all areas of the economy, especially healthcare. This has impacted the need to educate nurses that can appropriately care for a diverse population. Nursing education has been charged with educating students to develop knowledge, skills, and attitudes, which promotes awareness of culturally diverse individuals. Studies on the education of nurses indicate that when cultural content is included in the curriculum, cultural competence among students is increased (Mesler, 2014; Musolino et al.; 2010; Reyes et al., 2013). What follows is a brief summary and synthesis of the extant research published between January 1, 2015, and March 15, 2020, describing levels of cultural competence among BSN students, the efficacy of programs designed to enhance cultural competence among BSN students, and evaluations of cultural competence among practicing nurses.

Nursing Education preparation and Cultural Competence

Since the initiation of the mandate to incorporate culturally competent content into the curriculum, nursing education programs have been challenged to meet the expectations of developing culturally competent nurse graduates ready for entry into practice. Nursing educators have not been consistent in the way that cultural content is taught, and there is no consensus as to the best method for teaching cultural content and increasing cultural competence (Easterby et al., 2012; Kardong-Edgren et al., 2010; Long, 2012).

Byrne (2018) conducted a mixed-methods study comparing the effectiveness of two educational programs designed to increase cultural competence among 38 undergraduate nursing students in the United States. The first program delivered cultural content in a lecture format, while the second program used a lecture plus simulation format using standardized patients. Levels of cultural competence were assessed using the inventory for assessing the process of cultural competence (IAPCC-Student Version) (SV). After the education was delivered, a debriefing was conducted with the participants in the standardized patient group. Participants were between 17 and 20 years old, and most were female, White, and spoke English as their first language. Scores on the IAPCC were increased significantly from cultural awareness pre-education to cultural competence post-education. There were no significant differences in the post-education scores between those who attended the lecture only course and those who attended the lecture plus simulation course. All the participants in the standardized patient group made

positive comments and found the simulation experience to be valuable. The perceptions of those who attended the lecture only course was not explored.

Similarly, Stiles et al. (2018) conducted a quasi-experimental study to compare the effectiveness of integrating cultural content into the curriculum (control group) to a stand-alone culture course with simultaneous field experiences (treatment group) at increasing cultural competence among undergraduate nursing students. All 53 students in their junior year received the treatment, and 19 students in their senior year were included in the control group. The control group had a larger White representation of 72% and under 25 years of age 76%, while the treatment group was noted to have a larger representation of Native Indian, /Hawaiian, Asian, Black, and Hispanic, with only 34% White. The Transcultural Self-Efficacy Tool (TSET) consisted of three subscales (cognitive, practical, and affective) and was used to measure participants' self-reported ability to provide culturally sensitive care. Post education, Transcultural Self-Efficacy Tool scores were significantly increased compared to baseline among students who received the experimental treatment but not among controls. When compared to the controls, the post-education Transcultural Self-Efficacy Tool scores of the students in the experimental group were significantly higher. The strength of this study was the quasi-experimental design and that the sample consisted of a more diverse student population than prior studies. However, a limitation identified was the unbalanced distribution among participants in the control group (homogeneity) and the treatment group (diverse).

Grower et al. (2019) completed a longitudinal study on cultural competence among 66 Australian nursing students following an international service-learning

experience. The IAPCC-SV was used to measure the cultural competency intermittently over a period of 12 months and 23 participants. The results indicated that the immersive experiences resulted in immediate improvements in IAPCC-SV scores, which were sustained over time. Nonetheless, the participants' scores improved between time 2 to time 3 and remained in the culturally aware, skill, and knowledge category. Strengths of the study were the longitudinal research design, and that cultural competence was measured while students were immersed in providing care to diverse populations, simulating the work environment.

A well-designed educational program can improve cultural competence no matter the method of delivery (Byrne, 2018). However, combining stand-alone courses with simultaneous field experiences were noted to be more beneficial in improving cultural competence. The use of immersive experiences provided the most impact in terms of sustained and immediate improvement in cultural competence (Gower et al., 2019). All of the studies found that significant improvements in cultural competence had resulted from exposure to cultural education. However, the methods used to provide cultural education varied greatly across studies and included stand-alone courses (Byrne, 2018; Schuessler et al., 2018), field experiences (Grower et al., 2019; Schuessler & James, 2018), simulation (Byrne, 2018), standard integrated content (Schuessler et al., 2018), and a combination of methods (Byrne, 2018; Schuessler et al., 2018). Despite the observed increases in cultural competence that resulted from cultural education, the differences between the studies on design and in the types of educational methods examined provided little evidence for increased effectiveness of any educational method.

This review of current publications highlights the relevance of this study by highlighting the need for qualitative research to expand our understanding of the effects of different types of academic preparation on levels of cultural competence post-graduation. The next section provides a synthesis of cultural competence among practicing nurses.

Cultural Competence in Practice

Almutairi, McCarthy, and Gardner (2014) studied cultural competence among practicing nurses in Saudi Arabia. Most of the participants were expatriate non-Saudi nurses (NSN) from other countries. The authors used a qualitative case study design and Campinha-Bacote's (2002) the process of cultural competence in the delivery of healthcare services (PCCDHS) model as the conceptual framework. All participants had at least 1 year of hospital experience. The authors noted that the NSN demonstrated a few of the constructs depicted in the PCCDHS. Ethnocentrism played a major role in the interactions of NSN with patients; this created barriers to the development of cultural competence. Other emergent themes included culture shock and disempowerment. The official language within the hospital was English, however, the local population did not speak English, and the staff did not speak the local language, making communication difficult and resulting misunderstandings; thus, most of the reflections on culture shock were related to language barriers. The NSN also reported that they had no control over the rules of conduct in the hospital setting and felt a loss of control over professional situations. The study is novel in that it highlights the challenges faced by nurses practicing in a culture different from their own. This is supported by Almutairi et al. (2017) study of nurses in Canada. In their study findings, the way people conceptualized

differences and their cultural upbringing shape their heritages. The influence of the nurses' country of birth, age, and experience influenced their perception of cultural competence and its effects on caring for a multicultural population.

Mareno and Hart (2014) compared the perceptions of nurses with undergraduate degrees to nurses with graduate degrees on cultural competence when caring for patients and families from diverse populations. The Clinical Cultural Competency Questionnaire was used to assess levels of cultural competence among the participants. The sample consisted of 365 nurses from a state in the southeastern United States. Participants were predominantly White, female, currently employed, and spoke no languages other than English. The groups were similar in age and number of years since licensure. However, nurses with undergraduate degrees worked primarily in the hospital setting, while those with graduate degrees did not. Most participants reported having received little or no workplace training on cultural competence. The Clinical Cultural Competency Questionnaire subscale scores were at a moderate level for cultural awareness, but at low levels for cultural knowledge, cultural skill, and comfort during encounters/situations. Nurses with graduate degrees had significantly higher levels of cultural knowledge compared to undergraduate nurses, but there were no significant differences between the groups on any of the other subscales of the Clinical Cultural Competency Questionnaire. The sample was gathered from nurses working in a variety of settings, which helps support the external validity of the study findings.

Similarly, Kouta et al. (2016) examined levels of cultural competence among 170 Greek nurses before and after a training workshop on cultural competence. The

Papadopoulos, Tilki, and Taylor model was used to frame the study. The participants represented a broad range of ages (26-62 years) and practice settings. Most were female and reported having frequent contact with people from other nationalities. The results demonstrated that community nurses who participated in the workshop significantly improved their level of cultural competence. The longitudinal pre- and post-test design was a strength of this study.

Silvestri-Elmore et al. (2017) compared perceived levels of cultural competence among 126 nurses who had graduated from nursing school within the past 12 months and had received cultural education during nursing school by way of either: a stand-along course, integration of cultural content throughout their nursing curriculum, or cultural immersion experience. A nationwide sample was recruited for the study. Perceived levels of cultural competence were measured using the Clinical Cultural Competency Questionnaire. Hispanic ethnicity and the length of time since entering the practice setting were associated with higher levels of cultural competence. The majority of participants (n = 124; 98.4%) reported that they had received cultural education through content integrated into their courses, but those who participated in a cultural immersion experience (n = 38; 32.2%) had significantly higher levels of perceived cultural competence compared to those who did not (p = .003). The stand-alone course and the integration of cultural content in the curriculum were not associated with higher levels of cultural competence among practicing nurses. Because some participants had received more than one type of cultural education, it is possible that the results observed among

those who participated in an immersive experience could reflect the cumulative effects of having received several types of cultural education.

Current studies have examined several aspects of nurses' ability to implement culturally competent care in the practice setting. Most of the studies have been quantitative in nature; only one study used a qualitative design (Almutairi et al., 2018). Two of the studies were conducted in the United States (Silvestri-Elmore et al., 2017), the remaining two in international settings (Almutairi et al., 2014; Kouta et al., 2016). The findings of the qualitative study by Almutairi, et al. (2014) indicated that a group of nurses who were members of racial/ethnic and religious minorities expressed ethnocentric ideas and experienced language barriers when caring for patients from the racial/ethnic majority represented in the practice setting which impeded their sense of control over their professional practice. Similarly, Almutairi et al. (2017) indicated that nurses who spoke the same language or culture scored higher perceptions of cultural competence. This indicates that nurses who are members of racial/ethnic and religious minorities may also have difficulty in practicing culturally competent care. These findings are relevant to nurses practicing in the United States because of the great diversity of the population. In contrast, Silvestri-Elmore et al. (2017) found that nurses who were members of an ethnic minority in the United States (Hispanic) had higher levels of cultural competence compared to other racial/ethnic groups. However, the participants of the study had received some type of cultural education, a factor that was not assessed in the study by Almutairi et al. (2014). Indeed, the findings of the remaining studies also indicated that having received cultural education contributed to

improvements in cultural competence among practicing nurses. Mareno and Hart (2014) determined that having a graduate degree was associated with higher levels of cultural knowledge, but that knowledge did not lead to culturally competent practice. Similarly, Kouta et al. (2016) found that training in the form of a workshop increased cultural competence among practicing nurses. The findings of this research are congruent with that of other studies (Byrne, 2018; Chen et al., 2018; Choi & Kim, 2018; Cruz et al., 2018; Grower et al., 2019; Kouta et al., 2016; Schuessler et al., 2018) which indicated that cultural training and immersive experiences influence the development of cultural competence. However, two studies found that nurses may lack the ability to translate cultural knowledge into the practice of culturally competent care (Almutairi et al., 2014; Mareno & Hart, 2014).

Limitations to these studies included the use of convenience samples (Almutairi et al., 2014; Kouta et al., 2016; Mareno & Hart, 2014; Silvestri-Elmore et al., 2017), the potential for recall bias associated with cross-sectional designs (Silvestri-Elmore et al., 2017), homogeneity of the participants (Mareno & Hart, 2014), and small sample sizes (Almutairi et al., 2014). Nonetheless, the findings indicated that despite the noted improvements in cultural competence that may be derived from exposure to training or education, there is a need for more qualitative research to explore BSN nurses' perceptions of their preparedness to practice culturally competent care and how they go about doing so.

Cultural Competence of BSN Students

Chen et al. (2018) studied the factors that contributed to the development of cultural competence among 106 students enrolled in either an associate of science in nursing program or an RN to BSN program at several universities in the United States. The researchers used the IAPCC-SV to assess cultural competence. The findings of the study indicated that participants exhibited moderate levels of cultural competence overall. Having experience in a health-related field was associated with significantly higher scores on the cultural skills subscale of the IAPCC-SV. However, cultural encounters and cultural knowledge were the strongest contributors to the development of cultural competence.

Choi and Kim (2018) conducted a cross-sectional study of 236 South Korean BSN students comparing the effects of cultural education and cultural experiences on levels of cultural competence. Cultural competence was measured using the Cultural Competence Scale (CCS), a 27-item instrument with five subscales (knowledge, skills, experience, awareness, and sensitivity). The average score on the CCS was in the moderate range, with the cultural awareness subscale having the highest average score (4.04 out of 5) and the cultural skills subscale receiving the lowest score on average (2.50 out of 5). Previous exposure to a variety of personal cultural experiences and having received cultural education were associated with significantly higher scores on the CCS. The strongest predictor of increasing cultural competence was having received cultural education ($\beta = 0.280$, $p < .001$). These findings were in contrast to those of Chen et al.

(2018), who found that having received continuing education credits or formal education had no association with levels of cultural competence.

Cruz et al. (2018) studied the cultural competence among 2,163 BSN students in nine countries outside of the United States to explore associations between respondents' demographic characteristics and their levels of cultural competence, measured using a 20-item version of the CCS. The findings found a moderate range of cultural competence, as was found in Chen et al. (2018). The scores on the CCS averaged in the moderate range of cultural competence overall, but there was substantial variation by country. Gender, increasing age, year of study, having received cultural training, experience taking care of diverse patients and special populations, and living in a culturally diverse environment were associated with significantly higher levels of cultural competence. Students in their fourth year of study had significantly higher scores on the CCS ($p < .001$) when compared to students in their second and third years of study, whether or not they had received any training in cultural competence. These findings indicated that while students may enter BSN programs with a moderate understanding and capacity for cultural competence, exposure to culturally diverse populations during their BSN studies contributes to the process of becoming culturally competent. However, Cruz et al. (2018) proceeded with an individual item analysis of the CCS, and the results indicated that students were not confident in their abilities to discuss health beliefs and behaviors with their clients based on nursing knowledge. The implication is that knowledge gains in cultural competence that are achieved while enrolled in a BSN program may not be enough to meet the challenging demands of the practice setting.

The findings of all three of the studies indicated that current levels of cultural competence among BSN students are in the moderate range and that experiences with culturally diverse populations, whether personal or professional in nature, are important contributors to the development of cultural competence among BSN students (Chen et al., 2018; Choi & Kim, 2018; Cruz et al., 2018). However, there were also some discrepant findings between the studies. While Choi and Kim (2018) and Cruz et al. (2018) found that students generally lacked confidence in their ability to apply cultural skills, Chen et al. (2018) found that students who had cultural experiences were confident in their cultural skills. Another discrepancy was regarding the contribution of training and formal education to the development of cultural competence. In the international studies by Choi and Kim (2018) and Cruz et al. (2018), training and education in cultural competence were associated with significant increases in cultural competence among BSN students. However, Chen et al. (2018) found that having received continuing education credits or formal education had no association with levels of cultural competence. One possible reason for the inconsistency of the findings is that the studies by Choi and Kim (2018) and Cruz et al. (2018) took place in countries that display low levels of diversity within their populations. The study by Chen et al. (2018) was conducted in the United States, a country with a highly diverse population; thus, students may have felt more comfortable with their cultural skills by interacting with diverse patient populations on a regular basis. This may also explain why in the same study, higher levels of cultural knowledge were associated with increases in cultural competence, but there was no added benefit to acquiring that knowledge through formal training or education (Chen et al., 2018).

Limitations shared by all three studies were in the ability to generalize the findings, which was somewhat impeded by the demographic homogeneity of the participants, measurement differences (the IAPCC-SV vs. the CCS), and the use of self-reported instruments which have the potential for social desirability and response bias. More importantly, none of the studies shed light on the specific reasons why some BSN students feel more confident in applying cultural skills than others or what types of experiences, training, and education students find most valuable at enhancing cultural competence. This qualitative study is needed to provide an additional perspective that has not been considered by studies focusing on BSN nursing students: the application of culturally competent care in the professional setting.

Summary and Conclusions

The BSN graduate is faced with many challenges on a daily basis, among them is the expectation to provide safe and culturally appropriate care. The majority of the studies reviewed used quantitative designs with limited qualitative input. Those studies reported a moderate range of cultural competence among nursing students and practicing nurses. They also indicated that cultural education contributes to improvements in cultural competence, but the findings of these studies do not provide strong evidence regarding the relative effectiveness of the various modes of delivery. The absence of qualitative research has limited understanding of BSN graduates' abilities to provide culturally competent care and how cultural education contributes to those abilities. This suggests a need for a more in-depth exploration of their experiences. Meticulous preparation and planning are necessary when examining cultural competence, as it

cultivates complex nuances, but still, warrants continued investigation. The study used a qualitative design to investigate how BSN nurse graduates integrate cultural competence into planning care for a multicultural population. Further, the study contributes to the understanding of the types of cultural education received by practicing BSN graduate nurses and their perceptions of the value of cultural education. The findings could aid nursing education, faculty, and the governing bodies of nursing in determining the best way to cultivate cultural competence among nursing graduates one year into practice. In Chapter 3, I present a detailed outline of the research design, methods, data collection.

Chapter 3: Research Method

The purpose of this study was to understand the lived experiences of recent BSN graduates as they develop and implement cultural competence in planning care for patients from different cultural affiliations. Chapter 3 discusses the research design and why the use of a phenomenological qualitative standard was most appropriate for this study. This chapter also includes detailed descriptions of the introduction to the design and methods, the researcher's role, recruitment process, sampling techniques, geographic location of the study, the procedures for data collection and analysis, and any ethical considerations.

Research Design and Rationale

I used a qualitative phenomenological study to address the following research question: What are the lived experiences of recent BSN graduates (1 year or less into practice) of integrating cultural competence into planning care for a multicultural population? Phenomenology is a philosophical movement founded by Edmund Husserl. Husserl's phenomenology focuses on the detailed description of consciousness as experienced from the first-person point of view (Husserl, 1962). Additionally, Heidegger's interpretive hermeneutic phenomenology is used for studying human experiences. Phenomenology's aim in research is to describe as accurately as possible the phenomenon without any pre-given framework but remaining true to the facts (Giorgi, 1985). The concept of epoche´is central to phenomenology, as it is important to focus on the individual's reflection on the things they experience (Welton, 1999). Phenomenology allows individuals to respond to events and the meaning of their lived experiences

(Houser, 2018, p. 403; Wertz et al., 2011), which discloses the essence or structure of meaning inherent to the human experience through imaginative variations (Finlay, 2009). Phenomenology is the best method for this study because few studies have investigated this phenomenon from the participants and their experiences.

The central concepts of this study are cultural competence, new BSN graduate, and a multicultural population. Cultural competence, in essence, is a lifelong process of seeking and improving cultural awareness, cultural skill, cultural knowledge, cultural desires, and cultural encounters in working with individuals, families, and communities to provide culturally competent care (Campinha-Bacote, 2002). To achieve cultural competence, the nurse must develop the capacity to progress through the interrelated concepts, which aligns with Campinha-Bacote's model. A BSN graduate nurse was defined as an individual with a BSN degree who is practicing as a registered professional nurse one year or less (Kajander-Unkuri et al., 2014) and caring for a multicultural population in a hospital or home care setting in the United States. For this study, a multicultural population was defined as a group or group within the community that is formed by individuals from different backgrounds, cultures, ethnicities, and races, all seeking health care services within the same setting (Giger, 2007).

Role of the Researcher

My role as the researcher in this qualitative study was that of an observer–participant, who is defined as the involvement of this researcher as an active participant in the subject under study to thoroughly understand the subject without changing it (Houser, 2018). In this qualitative research design, data collection and analysis were

filtered through my perspective as the researcher. The researcher's development of self-awareness and engagement in reflexivity is essential, which includes a critical reflection on how the researcher's backgrounds, assumptions, positioning, and behaviors impact the research process (Hennink et al., 2011). My role as the researcher could be seen as a power relationship where the subjects being interviewed are intimidated by my position, facial expression, or gestures. To mitigate this occurrence, I did not push participants to answer questions they did not want to answer, neither did I share stories from my experiences or other participants' stories. Researcher bias was eliminated through bracketing.

Bracketing

The researcher's pre-conception about the topic requires full comprehension of the problem investigated and be able to bracket or hold these pre-conceptions to fully understand the lived experiences of the participant and do not impose a priori hypotheses of their skills (Creswell, 2007, p. 277). This bracketing allows the researcher to understand, interpret, and analyze the data more objectively (Creswell, 2007). The researcher sets aside their previous knowledge, feelings, or biases of the phenomenon investigated. Bracketing is a cognitive process of removing presuppositions and beliefs, remaining non-judgmental, and being receptive to data revealed (Carpenter, 2011). Bracketing allows for an accurate description of the phenomenon investigated. I put aside any biases related to the subject or topic during the face-to-face interviews of data collection. I was open to the influence of demographic data such as age and sex that may affect the interview observation–participation process. A reflexive attitude is also

required to acknowledge the influence of the researcher's bias and the effect on the research process.

Researcher Biases

I have been a nurse for over 30 years. In that time, I have served in many capacities in nursing, including clinical staff nurse, educator, public health nurse, nurse leader, and a student at the doctoral level in nursing education. I observed the changing demographics of the nation globally and locally and became interested in how nurses are putting cultural competency training into practice when caring for a multicultural population. Investigating how schools of nursing chose to teach cultural competence content and the outcomes of nurses one year or less in practice was the basis for the study. I graduated several decades ago with no courses or experiences dedicated to cultural competence. Thus, I explored how new graduates experience this phenomenon putting aside personal experiences and views and focus on the participants' account of their experiences and realities. I minimized bias by recruiting participants from the northeastern, southeast, west, and the midwestern United States and not directly from my place of employment; I did not have any personal or professional relationships with the participants. Hence, the issues or supervisory or instructor relationships with power over participants did not take place. A $10 gift card was offered as a thank-you incentive for participation in this study.

Methodology

Participant Selection Logic

The target population was BSN graduate nurses who have been practicing 1 year of less in a clinical facility, including hospitals, nursing homes, home care, or public health nursing settings in the United States and are working full or part time. “BSN graduate” was operationally defined as a BSN-prepared nurse with 1 year or less in practice. To enhance the probability of reaching saturation with a relatively small sample size (Kindsiko & Poltimäe, 2019) and reduce the potential for heterogeneity of the sample, nurses with an associate of science in nursing, associate degree in nursing, masters, and doctoral degrees were excluded from this study. There were no age limits; participants had to be fluent in the English language, but English did need not be their native language.

The use of purposive sampling allows the researcher to gain a deeper understanding of the experiences of a specific group of participants (Hennink et al., 2011). It ensures the sampling of more participants who have had experiences relating to this particular phenomenon. I used a purposive sampling method to recruit first-year resident nurses working in hospitals from each of the regions of the United States (Northeast, Midwest, Southeast, and West), which provided a variety of new graduates who have encountered a variety of multicultural environments and experiences after entering the profession and limited sampling biases. Purposive sampling also allowed me to gather in-depth, rich information relevant to the phenomenon of study. If there was a lack of participants, the use of snowball sampling was used to gain referrals from

participants. Participants were asked to recommend fellow nurses who possess the same criteria of BSN graduates who are in practice for one year or less. My contact information was provided for this purpose.

Sample size justification has been a debated issue in qualitative research (Sandwlowski, 1995). However, many researchers concluded that it is not contingent on the number of interviews but the principle of saturation. Saturation is when the researcher stops collecting data because fresh data no longer sparks new insights or reveals new properties (Creswell, 2014). The sample size is contingent on a number of factors relating to the epistemological, methodological, and practical issues of the research (Sandwloski, 1995). Studying approximately 10–15 participants is usually enough to obtain saturation (Groenewald, 2004). The inclusion criteria are guided by the goal of the study. There are three inclusion criteria that had to be met: (a) recent BSN graduates practicing 1 year or less, (b) must be a RN, and (c) must be working in a hospital or home care setting, or public health. Exclusion criteria included holding an associate degree in nursing or holding a master's degree or doctoral degree in any field. Potential participants were screened during the recruitment process. Those who were interested but did not meet inclusion criteria were notified of exclusion and thanked for their interest in the study. A sample was sought that included at least two participants from each geographical region of the United States.

Instrumentation

This study used two researcher-developed instruments: a demographic questionnaire and an interview protocol.

Demographic Questionnaire

A demographic questionnaire was administered to participants prior to the interview process (Appendix A). Data such as age, time in professional practice, and the influence of educational delivery of cultural content were gathered to describe the composition of the sample and to help determine whether the sample was representative of the larger population. The use of a demographic questionnaire allowed me to describe the characteristics of the participants. Past research in cultural competence demographic data such as age and cultural background has played an important role (Almutairi et al., 2015; Chen et al., 2018; Hart & Mareno, 2016; Sandell & Tuppy, 2015) in the level of cultural competence.

Researcher-Developed Interview Questionnaire

An interview protocol was used for this study (Appendix B). The interview protocol consists of five questions that were guided by the theoretical framework of cultural competence designed by Campinha-Bacote. I used a semi-structured interview technique with open-ended questions developed in advance, allowing me to use follow-up questions to probe the participant for clarity, interpretations, and practices (see Morse & Richards, 2002). The questions were developed to help participants share their lived experiences of caring for a multicultural population. For example, one question is “Tell me about your experiences in providing culturally competent care to your patients” (Appendix B). During each interview, participants were allowed to express their thoughts and feelings through specific questions. The participants were also allowed to add any information that provides clarity to their statements.

Content Validity

Research studies must be rigorously conducted to provide comprehension and conclusions that are true to other researchers, practitioners, and readers (Merriam, 2009). According to Creswell (2005), the validity of a study is confirmed if the measuring instrument actually measures what it intends to measure. Lincoln and Guba (2000) indicated that research findings should be secure enough to construct social policy or have legislation based on them. Although this qualitative study cannot change social policy or legislation based on the findings, the lived experiences of BSN graduates one year or less integrating cultural competence in planning care for a multicultural population will add to the body of knowledge by providing an understanding of their perceptions. These in-depth interviews provided enough detail to effectively conclude and answer the research question.

Content validity of the interview protocol was ensured by developing interview questions based on Campinha-Bacote's (2002) model of cultural competence and by eliciting the input of my committee members. This model has been used extensively in nursing research and education. Campinha-Bacote's model is divided into five concepts: Cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. The questions were designed to elicit responses that describe how each of the concepts is reflected through the individual experiences of participants (Almutairi et al., 2015; Hart & Mareno, 2016). These questions posed contributed to answering the research question: What are the lived experiences of recent BSN graduates (one year or

less into practice) of integrating cultural competence into planning care for a multicultural population?

Procedures for Recruitment, Participation & Data Collection

Participants were recruited using social media (Facebook, Twitter, Instagram) through an announcement. The second round of recruitment using social media and snowball sampling served as a strategic method for recruitment as more participants were required to reach saturation. The flyer included my contact information along with information about confidentiality for those eligible for participation. I first screened interested individuals for eligibility by asking two to three questions using the inclusion and exclusion criteria. I obtained an electronic informed consent from those deemed eligible for the study. The consent included information regarding the interview, voluntary participation, ability to withdraw at any time, access to transcript for confirmation, and publication of findings. I used numbers to mask the identity of each participant. In this way, confidentiality was maintained.

I sought a minimum of two or three nurses from each region (Northeast, Midwest, Southeast, and West) for a total of between ten and fifteen respondents; if additional participants were needed, then the other regions would have been included. The use of these specific locations allowed for a variety of regional dynamics that may affect how this cohort's interpretation of their experience relates to this phenomenon. I chose these specific locations for this study to see if there are similarities of differences between regions that impact the care of multicultural patients from BSN graduates one year or less in practice. Interviews were conducted via the secured platform Facetime in all the

interview processes to ensure that each geographic location were represented in the sample. At the point where no new themes were discovered, this indicated that the point of saturation has been achieved, and recruitment ceased. I conducted interviews and audio recorded the data collected from each participant verbatim. The data can only be accessed by myself and the committee chair. The frequency of data collection was based on the availability of the participants and conducted until the point of saturation. Participants were informed of the option to withdraw at any time during the study without explanation or questions. All participants were notified of follow-up interviews should there be a need for clarification of data. Audio recordings were obtained from each interview and copied verbatim into a written transcript. Enough participants were not available initially so there was a need to have more participants. A second round of advertisement on social media was conducted, and snowball sampling was used as an alternative method for recruitment. Fenner et al. (2012) discovered a high response rate at low cost for recruitment into a study using social media advertisements, and that subjects were highly engaged once recruited by this method. At the end of each interview, participants were thanked and informed of the option to receive a copy of the study after publication.

The method of data collection was one-to-one interviews between the participant and me. I transcribed the data verbatim from the audio-recordings of each participant. The duration of the data collection period depended on the number of participants needed to obtain saturation. Participants were notified in the event necessary clarification for verification of transcript. A written transcript of the participant's interview was available

for feedback and conformation. Data security was maintained securely by Flash Drive and backed up on my computer in a password protected file accessible only to me.

Data Analysis Plan

I used thematic analysis to guide the analysis. This allowed attention to relevant data and identification of specific themes emerging from the data, as well as the conceptual framework of the study that answered the research question. I utilized Colaizzi's (1978) strategy, which analyzes the data in seven steps (Sanders, 2003; Speziale & Carpenter, 2007) as follows:

1. Each transcript was read and re-read in order to obtain a general sense of the whole content.
2. For each transcript, significant statements that pertain to the phenomenon under study was extracted.
3. Meanings were be formulated from these significant statements.
4. The formulated meanings should be sorted into categories, clusters of themes, and themes.
5. The findings of the study was integrated into an exhaustive description of the phenomenon under study.
6. The fundamental structure of the phenomenon was described.
7. Validation of the findings was sought from the research participants to compare the researcher's descriptive results with their experiences.

According to Miriam (1998) and Creswell (2014), researchers should analyze the data simultaneously with the collection process to eliminate repetitions and provide

focus. This process facilitated the ongoing analysis of emerging themes and patterns. In the use of the specific sampling procedures, discrepant case sampling was not of concern as this phenomenological study is seeking an explanation, not modifying an emerging theory. All cases, negative or positive, were be welcomed to offer insight into the phenomenon.

I intended to use the qualitative software program NVivo to assist with analyzing the data and coding. This program has the capability of storing and organizing data in qualitative studies. However, there was numerous issues that could not be solved in a timely manner therefore, hand-coding was used to confirm significant statements, generating meaning and essence description (Moustakas, 1994).

Issues of Trustworthiness

Credibility

According to Lincoln and Guba (1985), to ensure confirmability and credibility is to ensure those participants being interviewed are qualified to discuss the phenomenon this researcher seeks to explore. The participants were screened according to the inclusion criteria for being qualified to participate in the study. Member checking is also known as participant or respondent validation and is used to confirm the credibility of the data collection. Participants are allowed to review transcripts of data collected to ask follow-up questions, clarify purposes, and to verify and establish credibility post-interview and analysis (Neuman, 2006).

Triangulation

According to Creswell (2013), when conducting qualitative research, at least two validation strategies should be employed. These strategies include Triangulation, member checking, thick, rich description, and peer review. Triangulation refers to gathering data by more than one method. Although this study was primarily dependent on interviews, when possible, observations of participants' behaviors were noted when conducting face-to-face interactions. Denzin (1978) described four types of triangulations: data triangulation, investigator triangulation, theory triangulation, and methodological triangulation. This study incorporated data triangulation (collection of data from different types of people) and methodological triangulation (use of observations, interviews, and field notes) by participants from different regions of the US, involving interviews, observations, and a demographic questionnaire.

Member Checking

Member checking was used to determine the accuracy of the data resulting from the final report on specific descriptions and themes of each participant (Creswell, 2014). Participants were asked to consent to follow-up questions for clarity and to confirm the information provided.

Saturation

Saturation was determined when no further themes or no new data that reveal any new themes (Creswell, 2014). The point of saturation was met when no new information or data is uncovered.

Reflexivity

I reflected on my role and how it shaped the direction of the study. I also reflected on the participants' personal backgrounds, culture, and experiences, which can influence the interpretation of the resulting.

Peer Review

In order to evaluate the worth to the professional discipline peer review were a part of this study approach. The mentor and committee member will review all data collected for compliance with this methodology.

Prolonged Engagement

Prolonged engagement is defined as contact with the participants until the end of the study. In this way, clarification can be done, and the facilitation of member checking (Houser, 2018). Participants were contacted via email to follow-up if deemed necessary until the study has ended. This is also included in the informed consent documentation prior to agreeing to participate.

Transferability

Transferability refers to the results of the study being able to transfer to situations with similar subjects and settings. The reliability of transferability can be jeopardized if assessments are performed over time, by different people, or are highly subjective (Creswell, 2003). A thick, rich description is the use of the participants' own words as much as possible to get as much detail, emotion, and context for a more in-depth understanding of the participants' experiences with this phenomenon (Creswell, 2007; Denzin, 1978). Variation in participation is another method to ensure transferability; this

can be accomplished by seeking a minimum number of participants from each region of the U.S. In this way, the setting and the sample of this study is adequately described to determine applicability (Houser, 2018).

Dependability

The repetition of the study with similar participants in similar circumstances will determine the consistency of the findings. I used an audit trail to chronicle all procedures and **to** document the process for this study. An audit trail describes how data were collected, analyzed, and interpreted (Cutcliffe & McKenna, 2004; Lincoln & Guba, 1985). The audit trail includes the audiotape recordings of the interviews, the exact transcriptions of the interviews, the field notes taken after each interview, and the reflexive journal of this researcher. This process helped to enhance the trustworthiness of the findings.

Confirmability

I ensured objectivity by reducing bias in all methods and procedures. Minimizing researcher bias was done in several ways, as described by Yin (2011). I followed the protocols in place for a qualitative study. Using audio recordings to capture the interview verbatim prevents adding or excluding data. I used bracketing of personal experiences, biases, and perceptions prior to conducting the research, allowing the participants to express their experiences without being influenced by the researcher.

Intra-Coder Reliability

Intra-coder reliability refers to ensuring that the application using the same processes and standards when coding individual responses. The adherence and accuracy

of the steps in the data analysis plan provided the consistency required. According to Yin (1994), the comprehensiveness of the steps taken during this research study in data collection and the use of multiple analytical perspectives (cross-checking codes, checking transcripts, constantly comparing data with codes, and writing memos about codes) contributed to the accuracy of the conclusions drawn. Specific steps in the data analysis process were followed to ensure intra-coder reliability.

Ethical Procedures

I sought approval from the Walden University IRB Committee (study # 03-04-21-0760978). The purpose of providing informed consent is to ensure that each participant understands what it means to participate in this study. Thus, electronic informed consent was provided to participants explaining the risks and benefits before initiating the interviews. Candidates were assured that no identifying information were retained in the study database. Confidentiality and identity masking of the participants using numerical pseudonyms were incorporated. Full transparency on the purpose of the study, their role in the study, and the disposition of the findings were communicated to the participants. Potential participants were informed of the interview process and that they may withdraw from the study at any time. Permission to be audio-taped with verbatim transcription of data was requested via the consent form, along with the risks and benefits of participation in this research study.

Possible ethical dilemmas of data collection and dissemination of findings can be mitigated by adhering to the procedures and applying the standards accepted by the scientific community. Confidential interviews were conducted at the convenience of the

participant regarding date and time. All interview responses were kept confidential and under the possession of this researcher in a password locked computer in a password-protected file. A $10 gift card was provided as a thank you for study participation. At the completion of the study, the recordings and raw data were retained for seven years and then destroyed.

Summary

This qualitative research study employed a phenomenological methodology that is applicable to the field of nursing. The purpose of this study as to understand the lived experiences of recent BSN graduates as they develop and implement cultural competence in planning care for patients from different cultural affiliations. I explored the experiences of new BSN graduates one year or less in practice, integrating cultural competence in planning care for their multicultural patients. The collection of data were one-on-one open-ended interviews guided by Campinha-Bacote's five subscales of cultural competence. The verbatim transcription, member checking, bracketing, triangulation, prolonged engagement with participants, and an audit trail will lend to the credibility and trustworthiness of the study. I used Colaizzi's process of phenomenological data analysis to describe the lived experiences of the participants. In this way, a rich description can be added to the body of knowledge about the experience of providing culturally competent care. In chapter 4, the analysis of the data is presented.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of BSN graduates with 1 year or less in practice integrating cultural competence in planning care for their multicultural patients. The research question directly addressed this purpose as well as the gap in the literature. In this chapter, I present the findings of this study. I describe the setting where the study was conducted and the demographics of the group of participants. A description of the data collection process, along with the data analysis process are presented. The results are organized based on the major themes that emerged from the data along with subthemes and exemplars of respondents' perceptions.

Setting

To my knowledge there were no personal or organizational conditions that influenced the participants or their experiences at the time of this study that influenced the interpretation of the study results. All participants were recruited and contacted via social media and using snowball sampling. The interviews were conducted in a comfortable, uninterrupted room in the participants home.

Demographics

The participants consisted of nine females and one male (N =10). Nine of the participants were between 19–25 years old, and one participant was between 26–30 years old. All participants reported having a BSN degree and had been practicing 1 year or less in a health care facility. Each interview was conducted via FaceTime, recorded, and transcribed verbatim. There were four Caucasian, four African American, one Asian, and

one Hispanic participant. Two nurses located in the Northeast, four nurses were from the Southeast, and four nurses were from the Midwest. The participant from the Western region declined to continue further in the study due to time constraints. Thus, this participant was not included in the data analysis.

Data Collection

Each person who responded to the recruitment materials was screened for eligibility. Four respondents were not included in the study as they did not meet the criteria, and they were thanked for their willingness to participate. Respondents deemed eligible to participate proceeded to the consent process. Those who consented to participation were then scheduled for an interview. To ensure confidentiality and anonymity code names and numbers were used to represent each participant (e.g., Participant 1, Participant 2). Data collection began March 2021 and concluded in April 2021.

Once the date and time were set, a FaceTime call was placed, which provided a secure platform for an audiovisual interaction. All participants were able to access FaceTime. The interviews were approximately 40 minutes in length and were recorded and later transcribed verbatim. Prior to concluding the interview, the participant was reminded that a follow-up call or email would be done after transcription to (member check) review the interview or clarify any ambiguous notations. Participants were also informed that they could refer friends who were similar in their educational status. The use of snowball sampling was beneficial, as most participants had peers who also were

new to the profession and were working 1 year or less. A total of 11 participants were recruited.

All questions were asked in the same manner, while allowing additional comments the participants chose to add to prevent any variations in data collection. I maintained an objective nonjudgmental stance to prevent any influence on the participants' responses. Each transcript was reviewed and coded after the conclusion of the interview. There were no unusual circumstances encountered during the data collection. While interviews were being conducted, I made field notes to note anything that either required follow-up or to make sense of the data. After completing all the transcriptions, I compiled a file with all the participants' responses to each question so I could reference each response in comparison to the other participants. This allowed me to analyze each question and develop codes and themes.

Data Analysis

Understanding the lived experiences of BSN graduates with 1 year or less experience integrating cultural competence in planning care for their multicultural patients was drawn from in-depth, semi-structured interviews with all the participants. Saturation was reached after interviewing the 10th participant. After each interview a transcript was generated and reviewed for errors. At the end of the data collection line-by-line extraction of key phrases and words repeated by participants was developed into several subcategories/subthemes, which were then examined to uncover the major theme or themes for each interview question. I attempted to use NVivo software for data analysis; however, there were numerous issues with the software on a Mac computer. I

resorted to manual coding of each transcript using Colaizzi's (1978) strategy for analysis. I reviewed all transcripts multiple times to ensure all were accurate. I used member checking, triangulation, and field notes to verify the collected data. Transcripts were emailed to participants to review prior to analysis to check the accuracy of the data.

During the data analysis, I noted any data that did not align with the emerging themes. At the conclusion of the analysis process, four major themes and 10 subthemes emerged. Throughout the review process of the data one discrepant case was noted. Participant # 6 stated she expressed that felt competent in cultural competency.

Evidence of Trustworthiness

According to Lincoln and Guba (1985), to develop trustworthiness in qualitative research four criteria must be met. Confirmability, credibility, dependability, and transferability were used to ensure those participants being interviewed are qualified to discuss the phenomenon this researcher sought to explore. Trustworthiness or rigor of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Polit & Beck, 2014).

Credibility

Credibility is necessary for establishing trustworthiness. The study was done according to the standard used in a qualitative approach. Techniques used to establish credibility included prolonged engagement with participants, persistent observation, member checking, and reflective journaling. Through the exchange of dialogue, trust was established between me and the participants.

I also developed an audit trail to describe how data were collected, analyzed, and interpreted (Cutcliffe & McKenna, 2004; Lincoln & Guba, 1985). In keeping with the dependability or stability of the data, the outcome of the findings must be consistent and trustworthy engagement, reflexive journaling, triangulation, and member checking was used. In this process of gathering, documenting, and analyzing the data, I was able to track the data in a detailed manner for any possible future audit of this study.

Transferability

To establish transferability in qualitative research, more in-depth probing and follow-up questions or clarification of any vague responses given by the participants which could be misunderstood as ambiguous were clarified by member checking (Creswell, 2014). In minimizing bias in collecting the data during the interview process, I maintained an objective, nonjudgmental approach so that I would not influence the participants' responses. I asked the questions in the same order and by the same audio-visual method. Transferability will assist the reader to form their own opinions about the quality of the research.

Confirmability

To ensure confirmability, I followed the protocols of a qualitative study by minimizing researcher bias. I maintained objectivity by bracketing of personal experiences, biases, and perceptions prior to conducting the research, and allowing the participants to express their experiences without being influenced by the researcher. I used the audio recordings to capture the interview verbatim preventing the addition or exclusion of data.

Dependability

Dependability is the ability to have consistency of the data over similar conditions (Polit & Beck, 2012). This was achieved when another researcher has the same findings with the same processes at each stage of the research process. Adhering to the qualitative research process and the use of an audit trail to document the process for this study will increase the level of dependability (Polit & Beck, 2012). The audit trail included the audiotape recordings of the interviews, the exact transcriptions of the interviews, the field notes taken after each interview, and my reflexive journal.

Results

This qualitative study was guided by the research question: What are the lived experiences of recent BSN graduates (1 year or less into practice) of integrating cultural competence into planning care for a multicultural population? The data were collected using a five-question interview guide (Appendix B). Descriptive phenomenology following Colaizzi's (1978) steps for data analysis was used to answer the research question. Four major themes were generated from participants' responses using this process: cultural competence is multidimensional, cultural knowledge through experiences, open communication is essential, and cultural accommodation through advocacy. The themes describe how recent graduates have integrated cultural competence into their nursing practices and how their educational preparation experiences have contributed to their current practices. The results are presented according to major themes with detailed descriptions of and examples supporting how each one was derived. The major themes, subthemes, and their corresponding examples are detailed in Table 1.

Table 1

Major Themes, Subthemes, and Examples

Major Theme	Participants	Subthemes
Cultural Competence is Multidimensional	1, 2, 4, 5, 9	Cultural Differences Acceptance Individualized Care
Cultural Knowledge comes through Experience	1, 3, 4, 5, 7	Educational Inadequacy Personal and Professional Experiences
Open Communication is Essential	2, 3, 6, 8, 9, 10	Taking the Time to Understand Overcoming Barriers Using Resources
Cultural Accommodation through Advocacy	6, 8, 9	Understanding Patient Expectations Creative Solutions

Theme 1: Cultural Competence is Multidimensional

All the participants described cultural competence as a multidimensional process involving an exchange or interaction between the nurse and the patient. The specific processes involved in this exchange were described by participants as understanding cultural differences, acceptance, and individualized care. The participants agreed that cultural differences exist and that an awareness or understanding cultural differences was important to the process of becoming culturally competent. However, the factors that participants acknowledged as contributors to cultural differences were inconsistent. Religion was the most frequently mentioned influence of their perceptions of cultural differences when caring for patients. Other factors that influenced cultural competence were race or ethnicity and attitudes regarding gender roles and gender identity. The intersectionality of these contributors to cultural differences in the practice setting was

acknowledged by most participants. Additionally, the layers of complexity that they encounter as new graduate nurses influenced the understanding of the full nature of cultural differences in the practice setting.

Participant #1 described a situation illustrating the intersectionality between ethnicity, religion, and attitudes toward gender roles: "most recently it was an Indian couple and I'm not sure exactly what their religious affiliation was, but they were very much against male providers." Several described cultural differences using the example of variations in attitudes toward pain and pain tolerance among certain religious, racial, and ethnic groups. Participant #5 described encounters in caring for members of a German American religious minority:

> the lady would always wear dresses, the man would wear some type of black shoes, black pants, and the lady would have some kind of scarf … their pain tolerance is very high. I remember working with the urologist [who] was doing a ventral circumcision … I look at his face, I can feel like he's not really numbed up, but he endures it.

Participant #9 linked a patient's expression of pain to her racial background "she was from Asian descent … she had a really flat affect even though, you know, she couldn't really tolerate pain."

Almost every participant emphasized the need to practice acceptance of diverse cultures in order to provide culturally competent care. Acceptance was derived through self-awareness or introspection and empathy. Participants identified awareness of personal cultural beliefs and attitudes as the means to developing an attitude of

acceptance when working with diverse patients. This was apparent in Participant #9's definition that cultural competence is "to be culturally competent you first have to know your own culture … your own perspective and accept other people's culture and perspective." Participant #5 stated, "you first have to know your own culture in your own perspective and accept other people's culture and perspective even though it differs from yours."

Acceptance was also expressed by maintaining an attitude of respect. Participant #2 commented that cultural competence "is a responsibility that everyone has to each other to understand and respect each other … so that we can all interact." A lack of respect for the other's culture was regarded as barrier to the achievement of positive outcomes. Participant #9 described one situation with a patient from a diverse racial background who was in labor. Referring to the physicians who were caring the patient, they said,

> the physicians were pushing her to have an epidural, although she did not want one … I think they were a little insensitive because they were not respecting her wishes … they just wanted to get the labor over with … you know, she wasn't an expressive patient you know, so it was hard for her to get her wants across.

Some participants further defined acceptance as a sense of empathy with the patient's worldview, implying that cultural competence was both a cognitive and an emotional process. Participant #4 commented that to provide culturally competent care, nurses need to "understand how that person views the world … to understand someone through their eyes or through their worldview."

Despite the need to understand and accept cultural differences, participants recognized that there are variations among individual members of diverse cultural groups and the need to individualize patient care. They recognized that everyone is unique despite their cultural background, and that they respected and tried to accommodate the needs of their patients. Participant #1 spoke of embracing the individual because "when caring for people … it's not all black and white, there's a gray area and we have to be sensitive to people's needs." Participant #2 emphasized the universal nature of the nurse-patient relationship: "ultimately you have to treat the patient like you would any other patient and just, you know, treat them with compassion and provide the best healthcare you can with your skills."

Theme 2: Cultural Knowledge Through Experiences

Participants expressed that they felt only somewhat prepared to practice culturally competent care due to the insufficiency of their educational experiences. Personal and professional experiences with people from diverse backgrounds were described as superior to educational training in developing cultural knowledge. Participants revealed that cultural competence education was infused into the different sections of the nursing courses. Some participants indicated that they were also required to complete one major project to research a particular culture and present it to the class. Although cultural information was integrated into the nursing curriculum of most programs, ensuring cultural competence was not described as a priority for the programs they had attended. Participant #1 stated,

> most of the cultural competence discussions that we had were definitely integrated through the program, it was not like a separate course…there was one section in the book that went over cultural diversity and cultural competence…but I can't even honestly tell you that was something that was on our test.

The cultural education received during nursing school was described as basic and focused on generalizations about the cultural practices of specific racial, ethnic, and religious groups. In line with the conceptualization expressed by participants that cultural competence involves the provision of individualized care, the tendency among nursing programs to teach cultural competence using generalizations about specific groups was regarded as especially problematic. Participant #4 expressed this in the strongest terms "what you learn is stereotypical in nature, and I'm not sure if it does more harm than good." In addition, programs tended to focus on the specific groups present within the surrounding community. This left some new graduates who chose to practice in other communities or areas of the country feeling initially unprepared to serve the cultural needs of that area. For example, Participant #3 commented that "it's not so much I feel prepared it's more like you're not sure who or what is coming to you." Participant #7 could be considered as a discrepant case in that she was the only one who felt she was prepared to provide culturally competent care. She stated that she felt prepared because there was one class that required that she complete a cultural project to present to the class and cultural competence was integrated into every nursing class.

Personal and professional experiences were described as the most valuable way to acquire cultural knowledge and build CC. Participant #1 commented, "I have to say

honestly I think most of my approach with my patients present day came from personal experience." Participants indicated that they developed cultural competence while on the job, through family connections or the cultural environment in which they lived and worked. For example, Participant #9 articulated she was prepared to deliver culturally competent care due to her personal experiences prior to nursing school and through her clinical experience in the hospital setting. She noted that she learned how to speak to people and to ask questions about their culture and not assume. She stated that cultural competence was not learned in school. Descriptions of the specific cultural groups that their experiences had prepared them to care for were often paired with an acknowledgement of the need to learn more. As Participant #4 explained,

> I think growing up in Florida like I'm pretty good…I understand people like from like Caribbean cultures and like Hispanic cultures…I wouldn't say that I'm necessarily prepared to understand like a lot of the intricacies of like Middle Eastern culture or West African culture or Indian culture because those are not cultures that I've had a lot of experience [with].

Participant #4 also expressed that his geographic location gave him an advantage as that area had a large diverse community. Academic preparation did not provide enough of an in-depth content on cultural competence but living and being immersed in that location allowed him to feel more confidence to provide culturally competent care.

Several participants provided further context on the value of experience by explaining how their own cultural background contributed to the level of comfort they felt in working with people from specific cultural or ethnic backgrounds. For example,

Participant #1 self-described as having a Mexican American family background and indicated feeling competent in caring for Spanish-speaking patients; while Participant #5 who self-described as Asian expressed frustration at needing to make eye contact when caring for "white people."

Theme 3: Open Communication Is Essential

Participants expressed that to provide culturally competent care, nurses must maintain open communication with patients and families. Open communication was described as key to overcoming cultural barriers. To achieve an environment of open communication, nurses must take the time needed to understand patient concerns and utilize resources to overcome obstacles to communication.

Participants described how they took time to learn about their patients' cultural preferences and to ensure that patients understood the treatment options that were available to them in planning their care. Most conveyed the use of questioning to learn more about their patient's culture, customs, and rituals and to keeping an open and respectful demeanor. The admission assessment was regarded as the best opportunity to learn more about the patient's cultural background and understand their expectations. Participant #2 stated,

> when we're doing admissions and you have to ask them 100 questions right… there's a cultural section on the admission portion so when you ask them about that, that can be kind of your opening where they are culturally so then you can kind of use that to delve in more to how you can help them during their hospital stay.

Participant #8 stated “I really have a process I think that's just like interacting with your patient you know, like when you're doing your assessment you know you wanna ask questions like you can kind of pick up on certain cues.” By completing a thorough cultural assessment, misconceptions about how to care for patients from diverse cultural backgrounds could be eliminated. Participant #3 indicated “I don’t put everyone in a box or assume that the patient adheres to traditional customs and practices.” She stated she asks a lot of questions of the patient or the family member who is present to learn how to care for that patient.

Several participants explained that revealing their lack of knowledge about a specific culture to their patients was helpful to establishing open communication. Participant #6 summed it up this way:

> I think [the] main thing is that I am just open and honest with the communication and saying you know, “I have not cared for someone of your ethnic background before” or “can you please do this a little bit of education or just tell me a little bit about your population so I can provide more you know confident care?”

Participant 7 expressed how she approaches patients from unfamiliar cultural backgrounds: “being open honest and saying I really don't know a lot about your ethnicity, or your religion please educate me if I say something offensive, please stop me.”

Participants described language as a barrier to open communication but used several resources to overcome them. They used the language line for consents and other legal driven information, but also used demonstrations, explanations, and the use of

actual equipment that would be a part of their care. Participant #4 “I feel like I just I take more time to explain like the reasoning behind things and like use more diagrams and like use more hand gestures when it comes to explaining like medical care to patients like who don't [understand] English.” Participant #9 voiced,

> I try my best that every time I'm speaking with a patient who has a language barrier at least to try to make sure that they understand me by using the language line or write down things for them, and that I think is one of the most important things.

Requesting the assistance of coworkers with foreign language skills to communicate with non-English-speaking patients was common. Participant #10 indicated that finding a coworker that could speak the patient’s language not only improved communication but seemed to make patients “more comfortable” in answering questions.

Theme 4: Cultural Accommodation Through Advocacy

Participants emphasized the need to accommodate the cultural preferences of patients whenever possible. They described offering accommodation first by taking steps to understand patients’ expectations regarding their care and then using the information to advocate for their patients when their wishes were being ignored.

> I had Hispanic patients that did not speak English very well and just like my ability to like speak Spanish kind of like really help them with their labor because like obviously when it comes to like legal items like legal documents and consent, we always had a translator

Participant #9 expressed,

> yeah so I had to advocate on behalf of one of my patients because she was Asian, she was from Asian descent, and she was in labor, and the physicians actually was pushing her to get epidural although she didn't want one.

The nurses were pleased that they were able to provide culturally competent care by intervening to accommodate the needs of their patients. They described advocacy as an important part of integrating cultural competence into their practices.

Participants described actions they took to make sure that their patients' cultural wishes were being addressed. Advocacy often required that the nurse develop a creative solution to ensure accommodation. Participants expressed that although they did not the understand the cultural traditions or rituals of some of their patients, they did what they could to accommodate them. Participant #8 explained how she advocated for her patient:

> my Muslim patient wanted to pray because it was Ramadan, … so after she would like you know come from her bathroom breaks before like I would tell her you know let's just hook you back up to the monitor, but you can like still you know sit down to pray.

Participant #6 demonstrated advocacy when she assisted a father in the delivery room:

> the husband asked at the time of delivery "can I have a pair of scissors. I need to cut a piece of my daughter's hair" for they do like a spiritual dedication ceremony, and they need a piece of the person, so [he] wanted to cut a little bit of his daughter's hair as way to honor her, and I said absolutely, and I put that in the in the notes so to pass it along in the report.

Several participants alluded to the fact that some cultural accommodations may be difficult to fulfill due to safety concerns. In such cases, coming up with a reasonable accommodation involved compromise. Participants explained that engaging in honest and open communication with the patient and family, helped gain their understanding and cooperation during emergent situations. Participant #2 described a situation with a family whose cultural background attached stigma to giving birth via cesarean section:

> We had a lady come in tonight at 29 weeks with pressures that were just so high…she didn't want to have a C-section and I said to her "listen, we want to send both of you home …right now the baby's not doing well, you're not doing well. We don't want to lose you guys." You have to have that conversation, yeah, because they don't understand, you know.

Participant #9 described another labor situation in which a couple had strong religious objections to allowing male providers in the delivery room during a cesarean section. Although every effort was made to accommodate the wishes of the family, the facility did not have a female anesthesiologist available to deliver the epidural. The situation required the nurse to serve as a patient advocate by facilitating communication between the family and the anesthesia provider. Through extensive patient education and dialogue between the nurse, the couple, and the anesthesia provider, a creative solution that was acceptable to all was developed: The anesthesiologist agreed to remain at the head of the bed behind a curtain to monitor the patient's vital signs to offer a degree of privacy; however, in the event of an emergency it would not be possible to maintain that set-up.

Summary

I conducted my study using a descriptive phenomenological approach. I interpreted the data using thematic analysis. I interviewed nine women and one man, nine of the participants were between 18 and 26 years old and one participant was between 26-30 years old. The questions I developed for the interview were designed to answer the research question and to understand the lived experiences of BSN graduates using cultural competence in planning care for their multicultural patients. Four major themes and 10 subthemes emerged from the data. The major themes identified in this study were, cultural competence is multidimensional, cultural knowledge through experience, open communication is essential, cultural accommodation through advocacy. In Chapter 5, I discuss my interpretation of the findings, the limitations of the study, my recommendations, implications, and conclusions of this qualitative study.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to understand the lived experiences of BSN graduates who had no more than 1 year in practice as they integrated cultural competence in planning care for their multicultural patients. This study was conducted to fill the gap in the research regarding how new graduate nurses practice cultural competence. The major findings generated by this study were (a) cultural competence is multidimensional, (b) cultural knowledge through experiences, (c) open communication is essential, and (d) cultural accommodation through advocacy.

Interpretation of the Findings

The findings of my study supported previous research that identified that being able to navigate a culturally diverse practice environment may enhance positive experiences among new graduates and patient outcomes (Chen et al., 2017; Silvestri-Elmore et al., 2017). A major theme in my study was that open communication is essential for cultural competence, and asking questions, being honest, and being patient is crucial for understanding the uniqueness of their patients' culture. The participants, although not comfortable with their abilities, were able to navigate cultural competence through experiences and open communication. However, most of the participants stated the educational preparation was inadequate and did not prepare them in cultural competence. Previous research has also indicated that culturally competent care has been deficient in face-to-face interactions, as nurses have cultural knowledge but not cultural competence (Mareno & Hart, 2016), and nursing students have lacked cultural knowledge, desire, encounter, and skill (Choi & Kim, 2018; Cruz et al., 2018). In my

study, most participants explained that the educational preparation did not fully integrate cultural competence experiences or in the curriculum, but they found ways to advocate, communicate, and acquire knowledge in their day-to-day practice.

Other research has highlighted a lack of autonomy to assist patients with cultural needs (Almutari et al., 2015). But I found that the nurses in this study acknowledged the patients' culture and with cultural accommodation through advocacy, they were able to plan care for their patients, which helped to cultivate their cultural knowledge and skill. Through this process, the nurses were empowered to advocate and plan the care of people from different cultures which helped their patients feel that their cultural needs were being met.

Another finding related to how the participants described what cultural competency meant to them, which was not supported in previous studies as most were quantitative in design. However, in previous studies, respondents did not elaborate on what their perception of cultural competence meant to them but how they interacted with their patients (Choi & Kim, 2018). For instance, cultural background could either be a facilitator or a barrier to cultural competence depending on whether the cultural background of the patient was congruent with their provider (Cruz et al., 2018). In my study two participants were able to identify with this finding, and stated they felt more confident in caring for diverse cultures as they themselves were from different cultures. Additionally, two participants were from countries outside of the United States and had varying perceptions from their cultures that influenced their perception of cultural competence.

Theoretical Context

The theoretical foundation of Campinha-Bacote's principles of cultural competence emphasized a journey and not a destination (2004). The PCCDHS model posits that the process involves the caregiver having an awareness of his or her own beliefs, values, and practices and an awareness and acknowledgment of the different cultures, values, beliefs, practices, and lifeways (Campinha-Bacote, 1999).

Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups (Campinha-Bacote, 2002). To achieve cultural knowledge, the health care provider must understand the worldview of the patient (Campinha-Bacote, 2007). For the participants in this study, cultural knowledge was a learned process through the interactions of the nurses working with a multicultural population, not through formal education or training. Therefore, the findings can be used to expand the model to include inter-cultural experiences in their professional roles as an effective source of cultural knowledge rather than relying solely on formal training and education. This was reflected in one of the major themes: cultural knowledge through experience.

Cultural skill is the ability to gather necessary cultural data that pertains to the patient's health problem and performing a culturally based assessment (Campinha-Bacote, 2007). The health care provider should be aware of the patient's physical, biological, and physiological differences to carry out the proper and appropriate patient assessment (Campinha-Bacote, 2007, p. 49). Cultural skill is dedicated to the implementation of cultural knowledge by observing, listening, evaluating, analyzing,

interpreting, relating, and communicating. One of the themes that emerged from this study was that open communication is essential. The nurses used open communication to gather information to assist in planning the care for their patients. They indicated that open communication was an essential for understanding and accommodating cultural needs. Because of the unfamiliarity with the encountered cultures, the participants stated they had to use questions, be open, be patient, and honest in learning the needs of each patient.

Cultural encounters are those interactions that are face to face, indirect, or other types of interactions with culturally diverse individuals (Campinha-Bacote, 2007). Cultural encounters also help practitioners learn about and understand different multicultural groups and help to eliminate stereotypes and ethnocentrism (Campinha-Bacote, 2007). The findings of this study supported the model by highlighting that for most participants all their encounters with people from diverse cultures occurred while developing their knowledge through their experiences in actual practice.

Finally, cultural desire is the motivation and desire to seek out opportunities to be exposed to different cultures to enhance one's cultural competence (Campinha-Bacote, 2007). Cultural desire is defined as the inspiration of the health care experts to "want to" become culturally skilled rather than perceiving participation as a "have to" scenario. Most participants indicated a desire to improve their cultural skills, but reported no plans how to do so, except for one participant who reported taking the time to develop some foreign language skills. Cultural desire can be linked to all the themes identified. The multidimensionality of cultural competence allows the participants to express through

their perceptions and description of what cultural competence means to them and influence their desire to learn more about each culture they encounter. Cultural encounter is linked with the obtaining of cultural knowledge through experience because of their interactions, and the development of their skills through the planning for their patients care through this interconnectedness.

The PCCDHS model helped to explain the attributes necessary in becoming culturally competent. The findings of the study revealed that BSN graduates were culturally aware when they entered practice but did not acquire the skills, knowledge, desire, or encounters until they were exposed to the multicultural population they served over time. The participants indicated that they asked questions to learn about and effectively advocate intently for their patients' cultural needs. The participants shared experiences when they were not prepared for a patient whose culture was unfamiliar but used open communication to determine patient preferences as to how they would like to be cared for in a cultural context.

Limitations of the Study

Although study participants were recruited from regions across the United States, the small size of the sample does not allow for the findings to be transferred to the larger population of US nurses. The trustworthiness of the findings was supported by the saturation of data noted in the participants responses. The use of a qualitative research design allowed for a more in-depth inquiry into the lived experiences of the participants. However, responder bias could have been a limitation of this research study. It was assumed that participants would provide honest and accurate responses to the interview

questions. However, participants could possibly exaggerate, understate, or deny experiences which can reduce the trustworthiness of the findings (Yin,2014). Additionally, as a novice researcher some content could have been missed, looking back more probing questions could have been asked to follow-up on participants responses. It is my hope that these skills will improve over time.

Recommendations

Current research on how recent graduates integrate cultural competence in planning care for their multicultural patients is limited. Future quantitative or qualitative studies can link the educational preparation with cultural competence by comparing the types of educational delivery with different cohort of nurses, such as, nurses who are immigrants to the US but were educated here. Other studies can also be conducted to investigate education implementing these choices of educational delivery (integration, stand-alone, or immersion). Service learning and immersive -community experiences could support the development of cultural competence among nursing students. Practice can improve confidence and exposure ensures familiarity with the different cultures seeking healthcare. This approach would allow for self-reflection, improve self-confidence among new BSN graduates, examination of stereotypical bias, promote equity, and social justice by serving all who seek healthcare regardless of race, ethnicity, or socio-economic background. Future studies can also focus on the cultural competence of nurses who have practiced for more than five years.

Implications

The results of this study contribute several implications for positive social change within health care organizations. First, the study provided evidence that participants felt unprepared to care for a multicultural patient population. They attributed this problem to superficial coverage of cultural competence during coursework and lack of appropriate field experiences. Nursing schools can use this information to reconsider the value of didactic cultural competence curricula versus offering more experiential opportunities. Nursing education can include immersive experiences in hospital, clinics, public health departments to expose students to diverse communities. Partnerships with health care organizations hospitals for extended residencies may provide a more robust experience in the development of cultural competence skills.

To prevent inequities in healthcare new BSN graduates must understand how to assess their patients' basic cultural needs and how to respond while maintaining patient safety and positive outcomes (Eche & Aronowitz, 2017; Mesler, 2014; Stiles et al., 2018). After obtaining those levels, the desire to learn more and the opportunity for more encounters will be realized. The use of Campinha-Bacote's model of cultural competence support the nursing curriculum and journey to cultural competence. Based on the findings of this study, it is the most comprehensive and provides guidelines that are essential to understanding how we perceive other cultures.

Conclusion

The study revealed that BSN graduates understand that achieving cultural competence is a complex and necessary goal in nursing practice. However, their

educational experiences contribute in a very limited capacity towards the development of cultural competence when caring for a multicultural patient population. Instead, nurses relied on personal and professional experiences to guide them in providing culturally congruent care. Participants reported that they used their communication skills to learn about patients' cultural preferences and thus effectively advocate for their patients' cultural needs. The inadequate preparation and inconsistent integration of cultural information did not inhibit learning through experiences to provide culturally appropriate care. Establishing the competence to practice in totality is the ultimate desire for nursing education, hence the ability to care for any member of our society no matter the gender, age, color, or cultural identity is the goal of the nursing profession (Kouta et al., 2016; Mareno & Hart, 2016; Prosen, 2016). The attainment of cultural competence can affect positive social change when new graduates are able to provide care for a multicultural population with confidence.

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Appendix A: Demographic Questionnaire

1. What is your age? (19-25), (26- 30), (31-35), (36-40), (41-50) (51 and above)
2. Gender? (male), (female), (other)
3. Where region of the U.S. do you practice in? Midwest, Northeast, Southeast, West?
4. Have you received education or training in cultural competence? Yes? No?
5. If your answer to the previous question was “yes”, was the training delivered through (choose all that apply):
    a. Integrated into the nursing school curriculum
    b. Stand-alone course on Cultural Competence
    c. An immersive experience (Travel or living in a foreign country for an extended period)?
6. How would you describe your race? (African American, Asian, Caucasian, Native American, Other).
7. Would you describe your cultural background as Hispanic/Latino? Yes or No.

Appendix B: Interview Questions

1. What does it mean to be culturally competent?

   Question 1 was designed to elicit the participant's definition or meaning of cultural competence. This question applied to the cultural knowledge. The response determines the understanding of cultural competence and the perception of this cohort in defining or explaining it meaning.

2. Do you feel prepared to provide culturally competent care in the clinical practice setting? Why or why not?

3. Tell me what you learned about cultural competence during your BSN program. Can you recall any specific aspects of what you learned?

   Question 2 & 3 investigate cultural desire and the academic preparation this researcher felt that understanding the educational preparation would provide insight into how the type of education influences the individual's practice.

4. Tell me about specific instances you provided culturally competent care to your patients.

5. Can you provide examples of any specific processes or procedures that you use to manage the care of your culturally diverse patients?

   Questions 4 & 5 explore the cultural encounters and cultural skill of the participant. This is meant to reflect how they go about using cultural knowledge and how they are implementing it in the clinical setting.

Finally, the participant was asked to fill in, explain, or clarify any issues or expand on any of the questions asked.