Phenomenological study of student nurses' preparedness for delivering culturally competent care upon graduation

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Abstract

Cultural competence is an essential requirement for delivering appropriate care to patients from diverse cultural backgrounds. An analysis of the literature revealed notions of cultural competence was mainly from the United States (US). In contrast, the number of publications in this field from the United Kingdom (UK) was limited. This study has provided an opportunity to critically examine student nurses' preparedness of cultural competence in their nursing training.

Campinha-Bacote's (2002) theory of cultural competence was adopted as a conceptual framework for this study. Data was collected through semi-structured interviews with ten student nurses recruited from one of the London universities. Data analysis was guided by Colaizzi's (1978) 7-stage analysis framework.

Four themes were generated. Firstly, student nurses' level of cultural competence; secondly, no formal cultural competence training in nursing curricula; thirdly, four clinical factors impacted on student nurses' cultural competence; finally, student nurses' recommendations on cultural competence development. The study findings suggested the development of cultural competence was best achieved through a multi-faceted approach from universities, healthcare organisations, and individuals.

Chapter 1: Introduction

1.1 Introduction

UK society has witnessed increasing cultural diversity in recent years. There are 7.8 million ethnic minority people living in the UK (Ethnicity facts and figures, 2020), which accounts for approximately thirteen percent (13%) of the UK population. This figure is expected to be between 20 and 30 percent (20%-30%) by 2050 (Office for National Statistics, 2020). The increasing diversity of the UK population creates a response to cultural competence among health care professionals. Student nurses are the main future health care workforce providing clinically competent care to culturally diverse patients, and cultural competence is an important part of clinical competence. This phenomenological study contributes to the knowledge around student nurses' preparedness of cultural competence, institutional and clinical factors impact on cultural competence, and recommendations of developing culturally competent care from student nurses' perspectives. In this chapter, I firstly illustrated the definitions of culture and cultural competence as the starting point for this thesis, followed by the conceptual framework used and, finally, background and rationale for the study.

1.2 Definitions of culture

While cultural competence is the key subject in this thesis, there is a need to first elaborate on culture because understanding the concept of culture helps to develop cultural competence. It is important to recognise that culture is not something that the individual is often consciously aware of, but it is a powerful influence on our way of life and our worldview, and is socially constructed. Culture shapes the way in which we express, experience, and cope with our feelings of distress and illness (Dayer-Berenson, 2014). It is for this reason that nurses seek to understand, appreciate, and respect cultural differences of diverse patients.

Due to the complex nature of culture, there exist many definitions of culture in the literature (Locke, 1992; Hofstede, 2001; Campinha-Bacote, 2002; Leininger and McFarland, 2006; Purnell, 2013). Culture, according to sociologist Locke (1992, p.3), is "socially acquired and socially transmitted by means of symbols, including customs, techniques, beliefs, institutions and material objects". Some authors

(Mason and Whitehead, 2003) consider these common customs such as how people dress, marriage, family life, work patterns, religious involvement, and leisure activity give social group a structure. According to Locke's definition, culture is learnt, not predetermined although one can argue that some of the culture characteristics come from birth that cannot be learnt or changed in later life, such as race and colour.

Social psychologist Hofstede (2001, p.9) defines culture as "the collective programming of the mind that distinguishes the members of one group or category of people from another". However, Dayer-Berenson (2014) argues that even the members of the same racial group may not share the same cultural experiences because culture can be influenced by the settings we find ourselves in and needs to be considered. For instance, in the context of health care, health and illness are interpreted by our personal experiences and our worldview which are culture-bound. This means the impact and meanings of illness to a patient could be different in comparison to those of a nurse or a patient with the same illness, but from different cultural backgrounds who may present with different clinical symptoms (Good and Good, 1981). Cultural misunderstandings resulted from stereotype of views can negatively impact on patient's clinical outcome. Therefore, being open-minded to the individuals' culture background enables nurses to deliver appropriate care to diverse patients.

The founder of transcultural nursing theorist Leininger (1991) believes nursing is a learned profession with discipline focused on care phenomena. She defines culture as "learned, shared, and transmitted values, beliefs, norms, and lifeways of specific individual or group that guide their thinking, decisions, actions, and patterned ways of living" (Leininger, 2001, p.46). Her culture definition has a significant influence in developing cultural competence in nursing education and practice, recommending integrating cultural care into nursing practice helps to achieve satisfactory health care outcomes.

Whilst many culture definitions exist in literature, there are two key views of culture: the essentialist view and the constructivist view. The essentialist perspective views culture as objective, stable and unchanging over time. From a health perspective, the essentialist view emphasises how religion, nationality, and race influence behaviours related to health and diseases (Garran and Werkmeister Rozas, 2013).

Education based on learning of beliefs, values or traditions specific to certain cultural groups is the key with that vision (Williamson and Harrison, 2010). However, this approach can potentially hide the diversity within a particular group as multidimensionality of health experiences and care practices exist in a culturally diverse environment. In contrast, the constructivist views culture as the product of social constructions. According to Carpenter-Song et al. (2007), culture is a dynamic relational process of shared meanings that originate in the interactions between individuals. This perspective considers a person's belief and behaviour are influenced by different conditions such as traditions, as well as by a broader socio-economical context. While social, economic, and political environment is constantly evolving, culture needs to be considered in historical, social, and economic contexts (Gregory et al., 2010). Gray and Thomas (2006) suggest that culture involves an ongoing process of transmitting and using knowledge that depends on dynamics in the society as well as global networks, it is not limited to race and ethnicity.

Purnell (2013), a cultural competence activist defines culture by its characteristics (see table 1) which concludes both essentialist's and constructivist's views. His definition highlights that culture does not only contain relatively unchangeable elements, which include essentialist views like race, age, and gender, but also influences factors that are highly likely changeable, which contains constructivist views, such as socio-economic status. The definition further emphasises the significant complex nature of culture.

Table 1: Purnell's culture definition (2013)

Primary cultural characteristics	Secondary cultural characteristics
Nationality Race Colour Gender Age Religious affiliation (potential to be changed)	Educational status Socioeconomic status Occupation Military experience Political beliefs Place of residence (urban vs. rural) Marital/parental status Physical characteristics Sexual orientation Gender issues Reason for immigration Length of time away from country of origin

Purnell describes culture consists of two characteristics (see table 1). Primary characteristics are: nationality, race, colour, gender, age and religion; and secondary characteristics including educational level, socioeconomic status, occupation, political beliefs, marital and parental status. He believes that primary characteristics of culture shape our worldview from a very early age which is generally unchangeable; whereas secondary characteristics come from life circumstances and life experiences and, as such, can and often change over time. In other words, secondary characteristics of culture can be learned and influenced by what individuals experienced in their life time. For example, people belong to the same racial group with differing secondary characteristics can have very different worldviews. They may not necessarily share a common culture due to different life experiences.

In relation to nursing, it is important to understand that culture is not only broadly referred as socially constructed ideas around race, ethnicity, religion, colour, gender, and nationality (primary characteristics); but also educational status, social economic status and personal experiences (secondary characteristics) because both characteristics can subconsciously affect people's thoughts and behaviours from different angles. As such, nurses need to consider individual's culture background including both characteristics in order to plan and deliver culturally competent care. Raising awareness and understanding of both cultural characteristics, particularly those changeable or secondary characteristics, according to Purnell (2013), are fundamental for nurses to deliver competent care that meets culturally diverse patients' needs. Research (Watt et al., 2016) revealed that patients have better outcomes when their needs are understood and met. Obviously, embarking on the journey of providing individualised patient care requires the nurses to learn culture-specific knowledge and skills, subsequently, become culturally competent. However, it is impossible for nurses to be highly knowledgeable about every culture. O'Haga (2001) recommends that respect and an open-minded approach to culturally different people, and a willingness to learn are the keys for good clinical practice.

1.3 Definitions of cultural competence

Cultural competence is a term that first emerged in the late 1980s and was defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency or amongst professionals to work effectively in cross-cultural situations (Cross et al., 1989). The development of a number of different theories and concepts of cultural competence has evolved over a period of time, reflecting different national contexts and concerns. Madeline Leininger (1998), a nurse and anthropologist in the US first used the term 'culturally congruent care'. She suggests that culturally congruent care can be achieved through co-participation of the nurse and clients working together to identify, plan, implement, and evaluate the care. Her pioneering work around cultural care in nursing provided a platform for the development of other models and frameworks in healthcare both in the US and internationally. The term 'cultural competence' has been often used later in the literature. The UK nursing educator Papadopoulos (2006) describes cultural competence as a process that needs to be continuously developed in order to enhance one's ability to give effective healthcare. Some authors (Duke et al., 2009; Gregory et al., 2010) also suggest the need to revise the concept of cultural competence by focusing on the process that cultural competence represents. Thus, cultural competence is not only about values, beliefs, and practices shared by a group of people, but also dynamic and evolving (Rogers and Knafl, 2000).

Due to the complexity of culture, the concept of cultural competence is also hybrid, and how to become culturally competent is contested in the literature. While some nursing competence can be measured objectively, cultural competence is significantly complex and multi-faceted. It is better to be understood as an ongoing process of learning and practising which evolves over time and requires constant commitment (Calvillo et al., 2009). The most consensual definition of cultural competence among several authors is the emphasis of the developmental, contextual, combinational, and integrative characteristics of the competence (Goudrea et al., 2009). Campinha-Bacote's (2002) suggests that becoming culturally competent requires integration of cultural awareness, knowledge, skill, encounter, and desire.

As cultural competence consists here of two inter-related concepts, culture and competence, definitions may vary depending on which component is in focus for

intended utility on the part of researchers. With culture in focus, the domains of culture may be presented specifically as cultural values, beliefs, and practice. If competence is the focus, the characteristics of competence may be manifested explicitly as cultural awareness, knowledge, and skills. However, some researchers (Campinha-Bacote, 2002; Giger and Davidhizer, 2004; Jeffreys, 2010; Papadopoulos and Lees, 2001) recognise cultural competence as a continuous, developmental, evolutionary, evolving, and dynamic process. What constitutes the definition or meaning of cultural competence, including such domains as cultural knowledge and skills are not static or finite and will change in response to the needs of the changing demographic and cultural context. This perspective may help health care educators and professionals to recognise that cultural competence is a dynamic, continuous, and developing process in providing culturally integrated and competent health care for culturally diverse populations.

Whilst a different focus on cultural competence has an impact on the understanding and education on cultural competence, a much broader definition of cultural competence is necessary. As Husband and Torry (2018) suggest, although individuals need to take responsibility for developing cultural competence, individuals alone cannot be held responsible for the delivery of culturally competent care services if insufficient resources are not made available. Betancourt draws attention at an organisational level which is focused on the healthcare system. He emphasises that a culturally competent system needs to be built on including an ‘awareness of integration and interaction of health beliefs and behaviours, at all levels, to achieve good outcomes for different patient populations’ (Betancourt, 2003, p.297). Incorporation of support from policymakers, educators and practitioners is impetus to meet the individual patient’s care needs.

Despite ongoing efforts to integrate a cultural perspective in health care systems, definitional issues have hampered conceptual and empirical progress in this field (Fuertes and Gretchen, 2001; Lakes et al., 2006). Given these differing terms and the conceptual overlap, the resultant confusion in interpreting cultural competency in nursing practice by educators and practitioners alike is not surprising. Although the general consensus suggests cultural competence broadly requires awareness of culture and application of this knowledge to diverse cultural backgrounds patients (Betancourt et al., 2003; Whaley and Davies, 2007), the literature still lacks a clear,

uniform definition, and key terms continue to be used interchangeably. For example, scholars modified language to accommodate the beliefs, attitudes, and behaviours of culturally diverse patients as culturally adapted, culturally sensitive, culturally responsive, and culturally competent without much distinction (Whaley and Davies, 2007). The conceptualisation of cultural competence is poorly understood among health care practitioners and providers due to lack of clarity in its definition (Gebru and Williams, 2010; Long, 2012). In addition, cultural competence frameworks differ in their utilisation, and most of studies focus on post-graduate level training. Such variations make evaluating the impact of cultural competence in the context of healthcare system challenging.

Whilst cultural competence has become embedded in professional accreditation standards worldwide, and some studies have identified beneficial effects of cultural competence on health care professionals' cultural knowledge, attitudes, and skills, and on the level of patient satisfaction (Cabral and Smith, 2011; Ceballos et al., 2010; Bhui et al., 2007), very few have explored cultural competence training for pre-registered nursing students. Despite the recognition of culturally competent care delivery being seen as an essential part of a nurse's role, there is no clear indication on how to ensure student nurses became more knowledgeable and aware of different cultural needs of patients in the UK (Holland and Hogg, 2010). Cultural competence training aims to improve the quality of health care and reduce health disparities by focusing on communication and trust between patients and health care providers, thus, patients' care needs are met. The training also tends to enhance provider's knowledge about socio-cultural factors linked to health beliefs, practices and utilisation of services (Betancourt et al., 2003). A nurse who does not recognise the value and importance of culturally competent care cannot possibly be an effective care agent in this changing demographic society (Gigger, 2016).

Of all the definitions of cultural competence, Campinha-Bacote's definition (2002) is the most quoted worldwide. She defines cultural competence as an ongoing process which incorporates culture awareness, culture knowledge, culture skill, culture encounters, and culture desire. It is "the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family and community)" (Campinha-Bacote, 1999; p.203). Her theory recognises that cultural competence is dynamic and complex, it is

evolving according to the specific individual's and social contexts. The essence of her theory involves comprehensive consideration of the meaning about both concepts: culture and competence. Whilst culture is socially constructed status that includes changeable and unchangeable elements; competence is about knowledge and skills set that can be achieved by constant learning and practising. Since the nature of culture is dynamic and evolving over time, becoming culturally competent requires constant commitment for learning and adapting (Calvillo, et al., 2009). Campinha-Bacote (2002) later transferred the five components into a cultural competence model, which focuses on not only static aspect of the cultural competence such as cultural awareness and knowledge, but also changeable and evolving perspectives of cultural competence such as cultural skills, encounter, and desire. The model has been widely used as theory-based evaluation in the health care settings internationally and approved as being effective. As such, Campinha-Bacote's theory of cultural competence will be employed going forward.

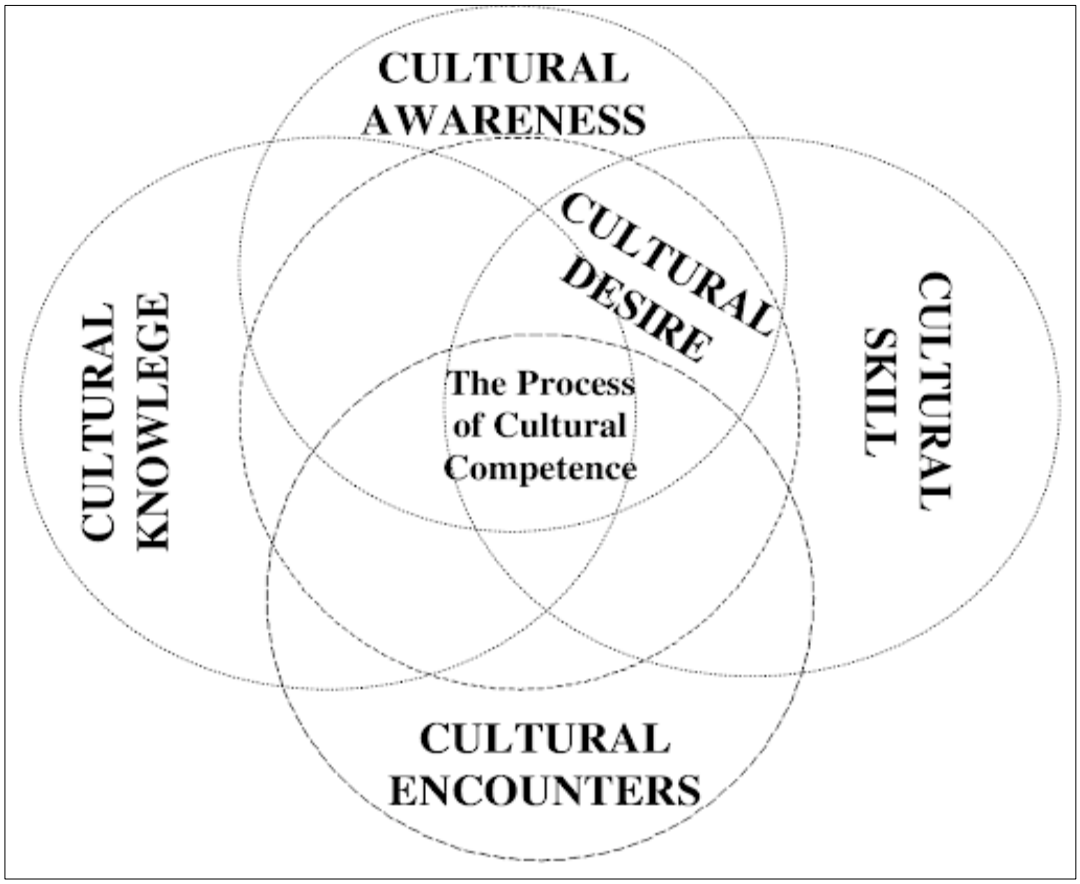
1.4 Conceptual framework

The purposes of conceptual frameworks are to bind the study, describe the relationship between the theories and experience identified by the researcher; and to organise the study's constructs for analysis (Miles and Huberman, 1994). Conceptual frameworks change as the study evolves (Yin, 2004). For this study, Campinha-Bacote's (2002) theory of cultural competence was chosen as a framework over others because its structure of five components (see figure1) provides clear guidance for cultural education and practice, and also, can be used as an assessment tool for the evaluation of student nurses' cultural competence. In addition, its practicality in diverse and international health care settings has already been approved to be effective with appropriate amendments (George, et al, 2015). Whilst the majority of cultural competence theories focus on one aspect of the competence, Campinha-Bacote's emphasises on the integrative natures of cultural competence based on specific situations of the patient. Although the theory was generated based on the study conducted in the US, issues in health care settings are similar in western nations such as the UK with increasing culturally diverse populations. Furthermore, studies from other nations such as Australia (Capel et al., 2007; Ingram, 2011) also demonstrated that with some modifications, the use of

Campinha-Bacote's theory as a framework was appropriate to assess and improve health care professional's cultural competence in Australian health care settings. Therefore, it is deemed suitable to be used as a framework for this study.

Campinha-Bacote views cultural competence as the on-going process in which healthcare providers continuously strive to achieve the ability to effectively work within the cultural context of the individual, the family, or the community. This on-going process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (see figure1). While cultural knowledge and awareness can be taught as sound learning base in the university, cultural skill, encounters, and desire have to be practised constantly based on different situations, individual patients, and specific contexts. Becoming culturally competent under the guidance of Campinha-Bacote's theory requires in-depth understanding of the components' definitions which are explicitly illustrated in the following paragraphs.

Figure1: Campinha-Bacote's five components of cultural competence theory (2002)



Cultural awareness is defined as “the deliberate self-examination and in-depth exploration of our personal bias, stereotypes, prejudices and assumptions that we hold about individuals who are different from us” (Campinha-Bacote, 2002, p.27). This process involves the recognition of the one’s own bias, prejudices, and assumptions about individuals who are different.

Cultural knowledge is “the process of seeking and obtaining a sound educational base about culturally diverse base” (Campingha-Bacote, 2007, p. 37). Obtaining cultural knowledge about the patients’ health-related beliefs and values involves understanding their worldview. The patient’s worldview will explain how he or she interprets his or her illness and it guides his or her thinking, doing and being (Campinha-Bacote, 2009). As previously highlighted that people’s worldview can be influenced by their culture background. For example, the presentations and interpretations of disease vary among ethnic populations due to their skin colours and beliefs, as such, the nurse who does not have accurate epidemiological data to guide decisions about clinical management will not be able to positively impact on patient health care outcomes. The lack of knowledge can lead to faulty data collection, and subsequently, ineffective clinical management. Hence, developing the ability to conduct a cultural assessment with each patient is required to deliver culturally competent care.

Cultural skill is the ability to perform accurate holistic health assessment, especially when performing a physical examination on ethnically diverse patients, one should be aware the differences in body structure, skin colour, and laboratory variances. Cultural assessment is a systematic examination of individuals as to their cultural beliefs, values and practices to determine explicit needs they require (Leininger, 1998). Interacting with culturally diverse patients requires effective communication and assessment of their linguistic needs, so that professional interpreters can be utilised when necessary to avoid misunderstanding of clinical management. Cultural skill is required to perform cultural assessment in order to provide individualised care to patients.

Cultural encounters refer to the method for effectively gaining deeper respect and understanding of a variety of cultures and traditions in a “sensitive and humanistic manner” (Campinha-Bacote, 2009, p.81). It is a process that encourages nurses to

directly engage in cross-cultural interactions with patients from diverse cultural backgrounds (Campinha-Bacote, 2002). Directly interacting with culturally diverse patients will modify one's existing beliefs about cultural groups and will prevent possible stereotyping from occurring.

Cultural desire is defined as "the motivation of the health care professional to want to engage in the process of becoming culturally competent" (Campinha-Bacote, 2002, p.88). Obviously, cultural desire involves the concept of caring because "people do not care how much you know until they first know how much you care" (Campinha-Bacote, 2009, p.183). Nursing is a caring profession, nurses are genuinely motivated to care and assisting with patients' health needs.

Campinha-Bacote suggests that the five constructs of the cultural competence care theory have an interdependent relationship with each other, and no matter when the health care professional enters the process, all five constructs must be addressed and experienced as cultural competence is an on-going process which involves the integration of the five components. George et al. (2015) recommend that the five constructs of the theory can be used as a framework in all health care settings including clinical, administration, research, policy development, and education. The five components are logical and integrated well into the process of becoming culturally competent, and its focus is not only on one factor but combination of both static and changeable nature of the cultural competence. This study intends to critically examine student nurses' preparedness in their nursing training, the theory serves as a clear guidance for the process of designing and constructing, data collection, and data analysis. Hence, it was chosen as a conceptual framework for this study.

1.5 Background to the study

As the UK society becomes more culturally diverse, nurses will need to be culturally adept and responsive to its relationship to health and illness. It suggests that health care practice requires changes that reflects and respects diverse values and beliefs (Leever, 2011). The UK Department of Health (DH, 2010) advocates that the NHS will focus on personalised care and reflect individual's health and care needs, ensure that everyone, whatever their needs or background, benefits from equity in access to

healthcare. For this reason, health care professionals are encouraged to be culturally competent in order to deliver quality patient care. While cultural competence is an expectation of professional practice in contemporary UK nursing, the variable and vaguely defined cultural competence definition has hindered the progress of developing student nurses' cultural competence. For example, in the American healthcare system, cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients (Betancourt et al., 2002); whereas in the context of UK healthcare settings, cultural competence is defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals that enables that system, agency or those professionals to work effectively in cross-cultural situations (George et al., 2015). The UK NMC (2004, p.27) also requires cultural competence in nursing practice, it specifically states that student nurses on qualifying should "practice in a fair and anti-discriminatory way, acknowledging the differences and beliefs and cultural practices of individuals and groups". In other words, student nurses are required to be culturally competent upon graduation. However, becoming culturally competent is a journey which requires support from Higher Education Institutions (HEI) and health care settings. Understanding student nurses' contemporary preparedness of cultural competence is a first step.

In the USA, trans-cultural nursing pioneers began to advocate in the late 1970s that experience and meaning of illness and treatment were rooted in particular cultural beliefs and values (Leininger, 1991). Literature in social sciences clearly indicate that health and the means to maintain, regain, or attain well-being are culturally defined (Angel and Thoits, 1987). Being culturally understood is, therefore, a good indicator of health and well-being and, for health care practitioners, cultural competence scaffolds better patient care provision. Hence, it is important to understand the student nurses' experiences of cultural competence, institutional and clinical factors impact on cultural competence and recommendations from student perspectives on what more can be done to promote cultural competence.

In comparison with the US, where trans-cultural nursing pioneers have made a huge impact in this area, it appears that the UK has a long way to go in order to achieve similar recognition of cultural care and cultural competence (Holland and Hogg,

2010). Although the level of cultural competence awareness among the UK health care professionals has improved over the last decade, consistent reports of lower rates of satisfaction on health care provision for diverse cultural background groups demonstrate that the UK health care system is struggling to meet the needs of culturally diverse populations (Schouler-Ocak et al., 2015). A nurse who does not recognise the value and importance of culturally appropriate care cannot possibly be an effective care agent in this challenging demographic society (Newman, 2016). It is, therefore, important to enhance cultural competence and integrate culture into nursing education and nursing practice. Research (Kirmayer, 2002) revealed that one of the challenges faced by nurses in increasing population diversity is the need to learn to decode the meaning of somatic and dissociative symptoms that are not simply indices to disorder but are part of a language of distress with cultural and wider social meanings. This could be the needs of diverse cultures, each with values and unique practices which can be overwhelming for nurses and other health care professionals to contemplate. It could also result in practitioners unnecessarily admitting and detaining the clients from those cultural backgrounds they may have difficulties in understanding or equating with their own. Hence, the increasing diversification of a society requires health care providers to act and think with the global perspective, so that they understand the importance that culture plays in people's perception of their health needs and in their responses to the health care services they receive (Leininger and McFarland, 2002).

In-depth understanding of student nurses' preparedness of cultural competence helps to promote quality of health care services and individual's wellbeing. While cultural competence training has been proposed as a strategy that facilitates the provision of cultural competent care (Dogra and Karim, 2005), it is widely variable in the UK health care settings in terms of their content, duration, delivery and assessment; and the assessment or evaluation is often done by subjective measures (Bentley et al., 2008). Despite increasing number of professional guidelines, health care policies and statutory requirements encourage cultural competence training; cultural competence in nursing education has not been standardised or carried out in a consistent manner (Workforce Race Equality Standard, 2015; Equality Delivery System, 2015). Evidence (Turner et al., 2014; Bhugra, 2008) suggests that cultural training in the UK does not adequately prepare health care professionals to meet the

needs of culturally diverse population. The sparse UK literature in this field has been criticised for being under-theorised, fragmented and piecemeal in nature and does not appear to be consistently improving over time in the UK (George et al., 2015).

In addition, older people from Black Asian Minority Ethnicity (BAME) are reported to suffer more chronic illness such as cardiovascular disease, diabetes, hypertension and stroke when compared to the majority (Evandrou, 2000). Language barriers are the major issues prevent them from seeking health care professionals' advice, hence, an appreciation of the health care needs of this group is vital in understanding the difficulties they face when accessing health care services (Toofany 2007). The increasing UK population diversity not only poses challenges to the health care services, but also to the care providers in terms of considering the diverse population's cultural needs (Sealey et al., 2006; Leisham, 2004; Leininger and McFarland, 2002; Gerrish and Papadopoulos, 1999; Salimbene 1999;). For example, with increasing population diversity, health care practitioners such as mental health nurses are more likely than ever before to encounter individuals from diverse cultural, racial and ethnic backgrounds in their practice. It is crucial to understand and appreciate cultures that are different from health care providers' in order to deliver individualised care. Changes in cultural composition of population means that health care practitioners are now expected to provide health care services that are designed to cater for groups in that society. This also means "health care services that are designed to cater for relatively mono-cultural populations" will be required "to review their ability to meet the needs of different ethnic groups" (Papadopoulos et al., 2004, p.108). In relation to the UK society, the increasing of culturally diverse populations requires not only health care providers, such as nurses to reflect on their level of cultural competence, but more importantly, policy makers and educators also need to raise awareness as to what change can be made in the health care system in order to meet individualised care needs for all cultural background patients.

Furthermore, concerns have been raised suggesting that health care in the UK is largely uni-cultural and ethnocentric in approach, whereby primacy is given to the majority white population and only peripheral recognition is given to the presence of the BAME groups (Public Health England, 2018; Sue, 2004). There is also evidence to suggest that nurses, alongside other health care professionals, lack the necessary

knowledge and skills to respond to the needs of people from a different cultural background to their own (Papadopoulos, et al, 2016; Hildenberg and Schlickau, 2002; Serrant-Green, 2001). Study (Serrant-Green, 2001) suggests that limited understanding of how cultural diversity within and between different migrant communities may affect health beliefs and behaviours as well as health care preferences which may imply nurses treat all patients according to the norms of the dominant cultural group. Hence, the above issues require the need to develop the necessary knowledge, skills and attitudes for nurses to practice within a multicultural society.

While health care providers are required to scrutinise the way in which their services are rendered, training providers such as universities are required also to re-examine their own roles in preparing students for entry into those service professions (Quality Assurance Agency, 2009; Brennan and Cotter, 2008; NMC, 2002). Specifically, training providers are charged with the responsibility of educating nurses “in ways that will enable them to provide care that is both efficient and culturally appropriate”, (Papadopoulos, 2006, p.8). This is because “culturally competent care is becoming a twenty first century imperative for those responsible for providing health care services in multicultural societies” (Papadopoulos, 2006, p.22). Cultural competence is recognised as an essential element or an explicit requirement by professional bodies for nursing education in the UK (NMC, 2015; QAA, 2001; 2009), However, such bodies do not necessarily give explicit references to cultural competence. Universities that offer undergraduate nurse training in the UK are, therefore, directed to develop cultural competence for their learners (ENB, 1997). They can exercise discretion in relation to how this is achieved, as they have great freedom to design their nursing education curriculum (QAA, 2009).

Reports in the US indicate that not all students in undergraduate nursing programs are receiving adequate content in cultural competence nursing and that, where it is received, the content is inconsistent (Fleckman, et al., 2015; American Association of Colleges of Nursing 2009; Mahoney, 2006; Dogra and Pokra, 2005; Hildenberg and Schlickau, 2002). Evidence (Truong et al., 2014) illustrate that cultural competence is an instrument which addresses diversity issues. Although some evidence (Papadopoulos et al., 2016; Papadopoulos and Lees, 2002;) suggests that efforts have been made in the UK health care workforce to prepare a more culturally

competent nursing workforce, some (DH, 2005; NSCSHA, 2003; Sainsbury cultural Centre for Mental Health, 2002;) are questioning that UK nurses are not ready to meet the challenges posed by an increasing culturally diverse UK society. One reason that has been contributed to this fact is that there is very little research that exists regarding how cultural competence could be integrated and addressed within the UK nurses training curriculum (Papadopoulos et al, 2016; Bhui et al., 2007). In addition, some scholars (Allen, 2010; Papadopoulos, 2006; Gerrish and Papadopoulos, 1999) were arguing that addressing cultural competence within the nurse curriculum remains controversial, and there is no clear consensus regarding how it should be taught or which theoretical or academic perspectives should underpin this teaching.

Even though cultural competence training is recommended as an expected key component of the UK undergraduate nursing curricula as requested by NMC (2014), evidence exists that does not feature strongly in current nursing education, and is indeed absent from many university nursing courses (George et al., 2015; Turner et al., 2014). These gaps in teaching and learning could be addressed by strengthening cultural competence in undergraduate nursing courses to promote nursing students' learning the complexities of cultural competence care provision (Allen, 2010; QAA, 2009;). Additionally, the lack of progress in developing culturally competent practitioners through nursing education programmes in the last ten years suggests a need for a conceptual framework to underpin development of cultural competence in nursing education. The perspectives of key participants need to be involved in undergraduate nursing education in the UK context, specifically nursing students. This is to ensure diversity of experience and it is clinically and educationally relevant.

Cultural competence is recognised as a legal requirement for nurses. The NMC code of conduct (2004) emphasises that nurses must treat every patient as an individual, respect their dignity, and do not discriminate irrespective of age, ethnicity or cultural background. However, there is limited attention to what this actually means for patients or staff, as such, it is difficult to establish how it might be measured (Papadopoulos et al., 2016). This reflects in the wider literature where there is no uniform definition of what constitutes cultural competence, and absence of what it means to the nurses and patients. In the UK, health and social care literature is not only unclear about the cultural competence definition, but also appears to use terms

cultural sensitivity, cultural safety, and others synonymously with that of cultural competence. If cultural competence is to be operationalised and its use and effectiveness measured, it is important to have a clear terminology for definition of what it is, particularly the awareness and understanding of its meanings for nurses, health care policy makers, and those charged with the development of cultural competence training programs. Research (Holland and Hogg, 2010) showed there was great uncertainty about desirability of cultural competence for nurses from all cultures in all care settings.

Several nursing accreditation bodies have instituted guidelines in cultural competence for their memberships which have now been made an explicit requirement for nursing education in the UK (NMC, 2015; QAA; 2009; 2001). For example, the NMC issues cultural proficiency guidelines for preparing nurses in cultural competence as an integral part of pre-registered nurse training (NMC 2015). NMC section 2 (NMC, 2001, S2.1) of the *"Professional Conducts for Nurses, Midwives and Health Visitors"* requires "nurses to recognise and respect the role of all patients and clients as partners in their care and the contribution they can make to it" without any form of discrimination. The NMC (2002) clearly expects nurses to respect diversity and culturally competent learning is seen as a lifelong objective. The NMC standards are in line with the earlier objectives of English Nursing Board (ENB, 1997) which endorsed educational standards that made explicit requirement the need for the UK nursing curriculum to prepare practitioners to deliver care in a multicultural context in order to enable them to challenge discriminatory practices. In particular, the QAA (2001) has emphasized that the cultural care needs, values and principles are to be an explicit requirement of nursing education in Britain. In developing the curriculum, the NMC (2015) encouraged educators and curriculum developers to design nursing programmes that should enable students to develop an awareness of the cultural diversity, values, beliefs and social factors that affect the context of nursing.

1.6 Rationale for this study

My own experience of understanding different cultures emerged as a consequence of three key influencing factors. Firstly, my own cultural background of being brought

up in China and having been living in the UK for twenty years has encouraged me to become culturally competent. Secondly, my encounters of colleagues and patients from diverse cultural backgrounds raised my awareness of culturally competent care in practice. Thirdly, I have witnessed many clinical incidents resulted from nursing colleagues' cultural incompetence. There exists insufficient cultural awareness, cultural knowledge, and cultural skills among health care professionals, which often lead to patients' complaints and incompliance to the treatment.

My own clinical experience demonstrated, on many occasions, that culturally incompetent care among health care professionals often result in compromised patient care and poor clinical outcomes. Miscommunication is a major issue that results in delayed care or care needs not being met. I, therefore, searched relevant literature from which I gained insight into the potential challenges nurses face when caring for patients from diverse cultural backgrounds. I realised how important it was to be culturally competent as a nurse in today's UK society. Antiracism and anti-discrimination as models of cultural education were also suggested in some of the nursing literature, but often lack structured teaching and learning strategies. In addition, racism is influenced by social, political, historical and legal factors, and it is a complex issue which requires systematic changes from the society to achieve success, efforts made solely from healthcare settings are insufficient. Whereas cultural competence involves antiracism and anti-discrimination behaviour but not limited to merely racial prejudice, it emphasises continuing learning and practising in order to create greater knowledge and skills for delivering individualised care to patients from all cultural backgrounds, and can be achieved by structured and ongoing training within HEIs and healthcare settings. This study intended to identify institutional and clinical factors impacted on competent care delivery, and make recommendations, hence, a cultural competence model was chosen.

Although some US studies showed effectiveness on improving nurses' cultural competence by using different cultural models and strategies in nursing education and practice, evidence within the context of UK student nurses is limited. Furthermore, issues including UK student nurses' level of cultural competence, experience of culturally competent care practice, and factors impact on preparedness of student nurses' cultural competence need to be addressed through research. The relevant information obtained through literature review further

encouraged me to conduct the study in the field of cultural competence in nursing, aim to understand student nurses' preparedness of cultural competence in their nursing training. The study findings are hoped to contribute to the knowledge around what more can be done to support the development of student nurses' cultural competence during their nursing training.

While some theorists (Giddens et al., 2013) suggest cultural competency can be developed through different approaches in nursing education at post-registration level, Mattson (1987) rightly argues that it may be too late to leave cultural competence issues until nurses qualify, and may be difficult to unlearn habits and prejudices. Therefore, it is necessary to emphasise the importance of integrating cultural competence into nursing education curriculum and throughout their clinical training at an early stage from the pre-registered training period. In this study, pre-registered student nurses from one of London universities are recruited. The aim of the study is to critically examine student nurses' preparedness in their nursing training for delivering culturally competent care upon graduation.

Cultural competence is viewed as a critical factor and essential component in providing relevant, effective, and culturally responsive services to the increasingly more culturally diverse population (Purnell, 2008; Campinha-Bacote, 2002). Over the years, applications of several major cultural competence models in nursing practice, education, research, and administration have been cited by many researchers such as Purnell (2008), Jeffreys (2006), and Giger and Davidhizar (2002). Although some well-known cultural competence models exist in literature, integration and measurement of cultural competence in practice remain difficult (Sagar, 2012). Improving cultural competency depends on health care professionals being supported in establishing such competence in the workplace (Kumas-Tan et al., 2007). The consensus of cultural competence concept is to integrate cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desires or motivation as a development process (Campinha-Bacote, 2002), so that cultural competence can be achieved. Conceptualising individual elements of cultural competence, however, is complex and contentious (Loftin et al., 2013; Horvat et al., 2014; Shen, 2015). Watt et al. (2016) suggest that central to culturally competent nursing practice is the recognition and incorporation of the dynamics of culture effectively into health care delivery.

Evidence also suggests that health care professionals and health care services need to be culturally competent so that patient needs can be met (George et al., 2015). In reality, cultural competence is often vaguely defined, poorly understood, and interchangeably used with other phrases, such as cultural sensitivity, cultural congruent care, and culture safety and so on in the literature (Diaz et al., 2015). The mixed terminology used for cultural competence has inevitably created a great deal of uncertainty as to what can be done to improve cultural competence in nursing training, and how to integrate cultural training into nursing education (lie et al., 2011). Therefore, this study presented an opportunity to explore student nurses' concept and experiences of cultural competence; to identify how institutional and clinical training impact on their cultural competence; and to offer deliverable recommendations from student perspectives for the development of cultural competence.

1.7 Summary

Cultural competence is an essential requirement for nurses in today's UK society. Since student nurses are the main future health care workforce, it is crucial to understand their contemporary level of cultural competence in order to identify what more can be done during their nursing training to achieve cultural competency upon graduation. Many culture definitions exist in the nursing literature. In this study, Purnell's definition of culture (2013) was adopted as it concluded the complex nature of culture by outlining its changeable and unchangeable characteristics. Purnell highlighted that people's thoughts, values and behaviours can be influenced by both characteristics but from different angles: the changeable characteristics are from people's early age, and the unchangeable through their lifetime. By understanding Purnell's culture definition, student nurses can appreciate why people have different thoughts and behaviours and the importance of being culturally competent. Whilst it is impossible to learn every culture, it is important for student nurses to understand and appreciate culture difference with open mindedness when encounter culturally diverse patients.

Similarly, variety of cultural competence definitions exit in literature. The emphasis is different dependent on its focus, either culture or competence. Campinha-Bacote's

theory (2002) serves as a clear guidance for designing, constructing, data collection and data analysis process of the study. Its five components including cultural awareness, knowledge, skills, encounter and desire can be used as a tool for assessing and developing student nurses' cultural competence. More importantly, Campinha-Bacote's theory takes into considerations of both culture and competence elements of focus, and recognises that becoming culturally competent is an ongoing process which requires constant learning and practising of those five components. Whilst the various definitions of culture and cultural competence in literature can be confusing, understanding the hybridity and fluidity of the nature of culture enables student nurses to appreciate how culture affects people's thoughts and behaviours, and why cultural competence is required for delivering appropriate care to patients from diverse culture backgrounds.

While US notions of cultural competence are rich and profound, the number of publications in this filed in the context of UK student nurses is limited. Evidence (Papadopoulos et al., 2016; Turner et al., 2014; Bhugra 2008) suggests that cultural training in the UK does not adequately prepare health care professionals to meet the needs of culturally diverse population. Furthermore, the UK literature in this field has been criticised for being under-theorised, fragmented and piecemeal in nature and does not appear to be consistently improving over time in the UK (George et al., 2015). In addition, my own professional experience of witnessing compromised patient care due to nurses' cultural incompetency has raised two questions: what is student nurses' cultural competency when providing care to patients from diverse cultural backgrounds, and does this equip them for delivering culturally competent care in clinical practice?

This study provided me with an opportunity to explicitly explore issues around cultural competence among student nurses in order to answer above questions. The aim of the study is to critically examine student nurses' preparedness in their nursing training for delivering culturally competent care upon graduation.

Chapter 2: Literature review

2.1. Introduction

The purpose of a literature review is to gain insights of a topic area and understand current literature before shaping a justification. In relation to this study, I intended to critically examine student nurses' preparedness of cultural competence in nursing training from UK HEIs and health care settings. The culturally competent care models and assessment methods in literature were examined and analysed in terms of their components, conceptual and theoretical backgrounds. Whilst cultural competence is significant in nursing practice, patient care and healthcare service delivery, the content of cultural competence is developmental and open for negotiation. As literature suggests cultural competence is an ongoing process that can be learnt, nursing education around cultural training was explored. Other related issues were also discussed, such as interventions to develop cultural competence on existing studies. Since the majority of studies were conducted in the US, and the number of publications in the context of UK health care settings is limited. This study's findings are hoped to contribute to knowledge of understanding student nurses' preparedness of cultural competence, and future interventions in developing cultural competence, particularly interventions in cultural training from universities and multiple clinical settings.

In order to undertake this review, it is necessary to design and develop an explicit search strategy to meet the need for producing a set of comprehensive and unbiased outputs that are relevant to the question under review. The key topic area relevant to this study is to critically examine student nurses' preparedness of cultural competence through exploration of their institutional and clinical experiences during their training. Relevant literature about nursing education on cultural competence and culturally competent nursing practice are incorporated into the background and context for the study.

2.2 Research question, aim, and objectives

The aim of this study is to critically examine student nurses' preparedness in their nursing training for delivering culturally competent care upon graduation. In order to meet this aim, the following three objectives were developed to carry out the study:

1. To critically explore student nurses' perceptions and experiences of cultural competence.
2. To identify factors of institutional and clinical nursing training impact on student nurses' cultural competence.
3. To offer recommendations for the progressive development of cultural competence from student nurses' perspectives.

The research questions generated from the literature review are: what is student nurses' cultural competency when providing care to patients from diverse cultural backgrounds, and does this equip them for delivering culturally competent care in clinical practice?

2.3 The literature review methods

In order to address issues of sensitivity and specificity and ensure the relevant literature was surfaced, national and international sources were included with the purpose of establishing a comprehensive understanding of cultural competence in nursing and other health care professionals. The primary purpose of the narrative literature review is to analyse the existing literature on focused topic and summarise the themes of research findings (Coughlan et al., 2007), from which new research streams are highlighted, gaps and inconsistencies are identified. This study is to seek understanding of student nurses' cultural competence preparedness in nursing training, which requires review of relevant literatures and identification of gaps between existing research findings and intended study focus. Hence, a narrative literature review method was approved to be suitable for this study. By using a narrative literature review method for this study, I firstly reviewed literatures relevant to the topic of student nurses' cultural competence; then generated themes of the research findings; and finally identified gaps between up-to-date research and current practice. The narrative review method also enabled me to develop research questions and a conceptual framework for this study.

2.3.1 Search strategy

This review approach focused on identifying relevant primary research that would contextualise and inform the development of the study, ensuring a clear perspective on the key issues relevant to cultural competence in practice and nursing education. Aveyard (2010) suggests database searching should be robust and justified, with an approach taken that balances sensitivity (locating all sources) and specificity (locating only relevant studies). As a precursor to undertaking the literature review a preliminary examination was undertaken to ascertain if reviews had been undertaken or were taking place, and to assist the clarification of appropriate and relevant search terms. The search terms were properly combined to obtain optimal results, they are: “culture”, “cultural competence”, “cultural sensitivity”, “student nurses”, “nursing education”, and “transcultural nursing”.

The search was conducted between June 2015 and August 2016, replicated between Septembers 2018 and August 2019, and a quick update in September 2020 when finalising the thesis prior to submission. Two separate literature searches were performed primarily in the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database and in Medline/PubMed. Google Scholar search was also used for potential leads to previously missed scholar articles and nursing practice guidelines. Reference citations in the reviewed articles and books were carefully examined for additional pertinent sources. In addition, the following databases or data sources were also examined for nursing education and guidelines: The Cochrane Database of Systematic Reviews (CDSR); The National Institute for health and Clinical Excellence (NICE); Current Educational Research in the United Kingdom (CERUK); The Royal College of Nursing (RCN); NMC; DH, Transcultural Nursing Association, and the European Transcultural Nursing Association. The Google Scholar search was conducted by using the terms “cultural competence”, ““cultural sensitivity”, and “transcultural nursing” and an author search for commonly cited authors in the field of cultural competence were also undertaken.

All articles included for the review had to be authored by healthcare professional researchers so that cultural competence was viewed within the context of the healthcare arena; were written in the English language; and were published between 2000 and 2019. The search strategy was established to ensure the credibility, validity, reliability and transferability of the relevant studies during the process of

review. As this study aimed to understand student nurses' preparedness of cultural competence through exploration of their experience of training and delivering culturally competent care in the local hospital, research conducted in the field other than medicine, nursing, and allied health care professional fields were excluded. In order to obtain an in depth understanding of the concept of culture and cultural competence, additional relevant databases were used for specific anthropology and sociology books and/or articles.

The Population, Exposure, and Outcome (PEO) framework guided the literature search process.

- Population (P): pre-registered nurses, OR student nurses, OR nurses, OR nursing, OR nurse AND
- Exposure (E) : cultural competence OR cultural competency OR transcultural nursing OR cultural safety OR cultural diversity OR culture OR cultural congruent nursing care
- Outcomes (O): to understand student nurses' cultural training in the HEIs and clinical settings; their clinical experiences of delivering culturally competent care; and interventions to help develop their cultural competence.

2.3.2 Inclusion and exclusion criteria

The literature was searched using the above terms and these were combined using Boolean operators to narrow the focus by using *, OR, AND to define the relationship between words and group of words. In addition, the inclusion and exclusion criteria as stated in table 2 and delineated in section 2.3.1 were used for initial retrieval of papers and specific limiters were applied.

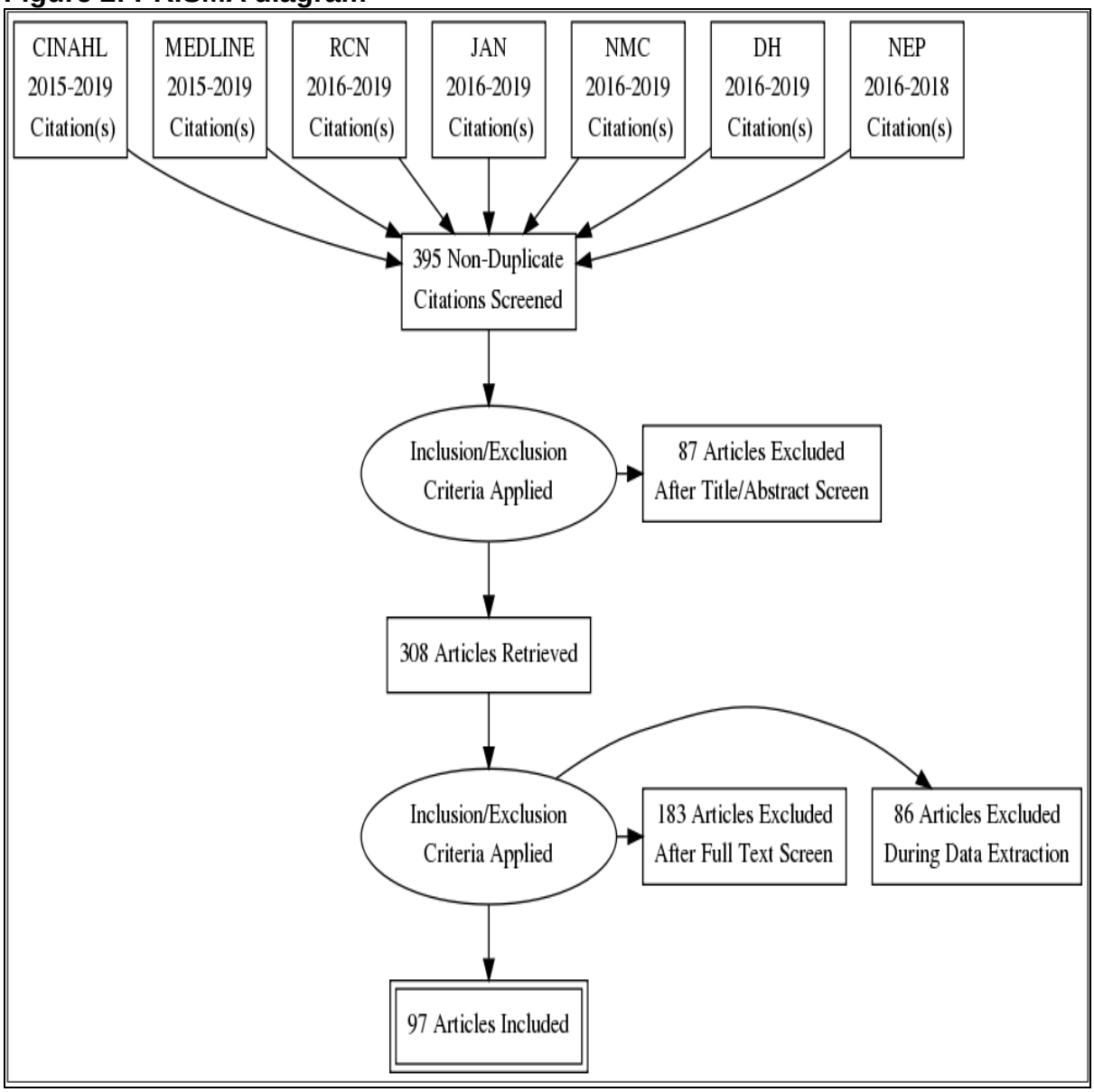
Table 2: The key inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Articles published after 2000	Articles published before 2000
Published in English language	Published in other languages other than English
Articles from peer reviewed journals	Articles that were non peer reviewed papers
Primary or secondary research, systematic or integrative literature reviews	Editorials and, or commentary and opinion pieces
Articles addressing aspects of cultural competence in nursing practice or nursing training	Articles addressing aspects of cultural competence not directly related to nursing practice or nursing training
Patient outcomes related to cultural competence	Patient outcomes relevant to other factors rather than cultural competence
Nursing education	Other healthcare professional's education

When conducting a review, methodological decisions have to be made regarding inclusion and exclusion criteria and rationale provided to justify the search method used (Hart, 1998). Date parameters ensured that the review was able to focus on the identification of relevant contemporary literature. A pre-date was set at 2000 until 2019 to enable capture of up to date and relevant literature. Furthermore, papers were selected from only peer reviewed journals. This was to ensure that only papers with suitable standards of quality and a high level of credibility were selected.

From this combined search 395 unique potential papers were identified. Titles and keywords were searched and any articles that did not fulfil the inclusion criteria across the databases were removed (N=87). The abstracts of the remaining articles (N=308) were then examined manually to determine relevance to the review questions and suitability based on inclusion and exclusion criteria. All papers which contained only medicine or allied healthcare professional's cultural training were removed. This resulted in the removal of 211 papers leaving 97 papers for the full screening as Figure 2. PRISMA diagram showed.

Figure 2: PRISMA diagram



2.4 Evaluation of relevant literature

A narrative synthesis was chosen as the appropriate method as it enables the synthesis of a wide range of different research designs, which includes both qualitative and quantitative, in a systematic and robust way (Lucas et al., 2007). It also provides in depth knowledge of what is currently known about cultural competency in nursing. The understanding of this field of knowledge helps to identify gaps in evidence and recommendations for nurses developing cultural competence.

Data was extracted in narrative form from each article, including research aim, findings, and discussion points. Each article was critically appraised using the criteria for methodological rigor from the Criteria Appraisal Skills Program (CASP, 2014) checklist, particularly with attention to justified data collection and analysis process, which results in credible research findings. The ten questions to assist with critical appraisal of qualitative studies recommended in CASP (2014) were used for the literature cited in the review. Qualitative studies that were of higher quality contributed more to the overall synthesis. They had more trustworthiness and transferability. With more details on context and more reflection, it allowed me to more confidently assess the importance of their findings. They also tended to contain more highly developed analysis within them. This was particularly important during exploration of relationships, comparing and contrasting data and developing themes across studies (Thomas and Harden, 2008).

The range of 97 articles including qualitative and quantitative studies explored views of nurse practitioners, nurse educators, student nurses, nursing policy maker and other healthcare stakeholders. Fifty four (54) articles were based in the US, eleven (11) were based in Australia, four (4) were from the UK, and remaining articles were from other western countries such as Canada, Sweden, Norway, and Netherlands. Most studies used a qualitative methodology and were of good rigor. Those articles displaying higher rigor were included in the study analysis.

2.5 The key themes of literature review findings

Following appraisal of the papers a number of key themes emerged relevant to understanding of UK pre-registered student nurses' awareness and practice of cultural competency. They are:

- Cultural competence training in nursing
- Interventions for cultural competence in health care settings
- Terminology used in literature and its impact on cultural assessment
- The impact of different cultural competence models

2.5.1 Cultural competence training in nursing

The Literature on this topic strongly suggests that culturally competent healthcare professionals are a necessity in today's healthcare arena and will play a crucial role in improving healthcare outcomes. Accreditation standards across health care professionals call for cultural competency education in order to prepare future healthcare professionals to care for increasing diverse populations effectively and efficiently. Studies examining cultural competence within pre-registered nursing education appear to agree that irrespective of model or teaching approach used cultural awareness and knowledge is enhanced but cultural competence is rarely achieved (Allen, 2010; Jirwe et al., 2009; Waite and Calamaro, 2009; Krainovich-Miller et al., 2008). However, given the suggestion that there is a lack of consensus as to how cultural competence should be taught (Allen, 2010), or which model or framework is the most suitable (Foronda et al., 2015), it is unsurprising that "educators are challenged" to create a suitable curriculum (Calvillo et al., 2009 p.138). It may well be that educational preparation primarily addresses the "Knowing that and why" of cultural competence rather than the "knowing how" in relation to this area of practice (Wilson and Myers, 2000, p.76).

Situated learning which embeds the "knowing how" may not have taken place during pre-registered education and nurses may complete the programme without sufficient interaction with patients from diverse backgrounds. It is unrealistic to expect rich cultural competence from student nurses as they lack clinical experience and patient contact. However, it is useful to understand student nurses' level of cultural competence, factors impacting on their cultural competence, and what could be done to support the development of their competency. This study provides an opportunity to examine whether cultural competence training is supported in the universities and clinical settings from the experience of the student nurses, and what recommendations they have come up with for the development of cultural competence.

Evidence suggests that cultural competence training for all major UK health care professionals including medical, nursing and pharmacists is inadequate (Bentley et al., 2008, Papadopoulos et al, 2016). According to one large scale study (Bentley et al., 2008) cultural training for healthcare professionals is not universal with approximately twenty five percent (25%) of teaching centres not providing one.

Bentley et al. (2008) suggest that even in those centres where cultural competence training does take place, the structure, methods and amount of teaching varies widely. The concerns are that without incorporating a dedicated cultural training into training programmes for the future health care professionals, it is unlikely that the students will acquire the skills required to deal with diverse population's health care. Other studies from the UK nursing educators (Papadopoulos et al., 2016; Holland and Hogg, 2010) also demonstrated that the education intervention of cultural competence had not been very successful. Hence, the UK regulatory professional health care bodies such as the UK Nursing and Midwifery Council (NMC) are urged to standardise cultural competence training for all health care professional students (Bentley et al, 2008).

It is suggested that the key to cultural competency lies in the ability of health care providers to "craft respectful, reciprocal and responsive effective interactions across diverse cultural parameters" (Barrera, et al., 2002, p.103). Supporting this claim, Hawala-Druy and Hill (2012) argue that teaching future health care professionals about specific cultures has been insufficient because it does not allow for the development of an understanding of cultural competence for application in practice. Therefore, educators should adopt eclectic culturally congruent teaching-learning strategies (Jeffreys, 2006) supported by concepts and theories rather than the traditional rigid approach of memorising facts in order to understand specific cultures. In addition, health care educators are expected to link and bridge cultural self-awareness, knowledge, theory and communication skills in teaching culturally competent care for health care professionals.

According to Omeri (2008), there remains a lack of formal, integrated cultural education into nursing. He reveals that there are similarities and differences in healthcare systems and nursing practice within diverse cultural contexts and societies. Global development of the discipline of transcultural nursing is dependent on international collaborative research efforts and the dissemination of knowledge worldwide. Although some educational interventions are designed to improve the cultural competence level of their students (Campinha-Bacote, 2010; Fitzgerald et al., 2009; Newcomb et al., 2006; Purden, 2005), Brennan and Cotter (2008) report that such interventions are neither robust nor efficient. The studies reflect the inefficiency of many current courses that aim to teach culturally competent health

care, utilise a method that places excessive emphasis on memorising cultural characteristics and clues, without sufficient focus on developing skills to apply this knowledge in practical settings. Students often have difficulty relating to topics of study as lessons are presented with little or no consideration of the cultural background of the students. The lack of interactive educational activities and a comprehensive approach to students' cultural and educational backgrounds result in a fragmented approach to learning and applying cultural knowledge. Instead, a more holistic approach needs to be adapted that would be more effectively suitable to the diverse student population and that would address all phases of developing culturally conscious attitudes.

After analysing education programs and teaching strategies to develop cultural competence among students and nurses, several authors (Long, 2012; Gebru and Willman, 2010) conducted methodologically rigorous studies which concluded that the conceptualisation and implementation of cultural competence is poorly understood among healthcare professionals and students. Harding (2013) and Gibbs (2005) claim that it is possible to develop cultural competence through nursing education. Teaching strategies would involve the development of capacities that go beyond knowledge of cultural customs and attempt to identify the causes of historical, social, cultural, political and economic inequalities in health care. Furthermore, Cooper et al. (2001) suggest that the earlier the students are exposed to culturally competent care within the curriculum the more likely they are to practice in a culturally competent manner following their graduation.

In addition, studies (Lie et al., 2013; Beach et al., 2005) also report insufficient information on the curricula, intervention or potential variables within studies included to ascertain any impact. Similarly, Gallagher and Polanin's (2015) meta-analysis of educational interventions to enhance cultural competence in professional nurses and nursing students suggest the need for greater transparency of curriculum interventions. They also report that despite these challenges there is some indication that qualified nurses benefit from cultural competency training more than students. Likewise, in a systematic review of interventions to improve cultural competency in health care, Truong et al. (2014) conclude that evidence in terms of patient outcomes is weaker than of provider outcomes or access.

Consensus across some of the reviews (Beech et al., 2005; Lie et al., 2013; Truong et al., 2014; Gallagher and Polanin, 2015) are the concerns regarding ambiguity in definition, language and terminology, and a lack of methodological rigour. The persistent confusion surrounding definition and understanding of key concepts have undermined clarity during educational preparation compromising the ability of educators to successfully connect the core constructs of cultural competence with day to day nursing practice (Truong et al., 2014). Whilst there is some limited evidence for the effectiveness of educational interventions, newly qualified nurses report not feeling confident or adequately prepared to deliver culturally competent care despite their formal training (Waite and Calamaro, 2009). As Whitehead et al. (2013) suggest, the newly qualified nurses may be clinically competent upon qualification but they "do not have the self-confidence to be an autonomous practitioner" (Whitehead, et al., 2013, p.371). In addition, "from the moment nurses are registered, they are autonomous and accountable" (DH, 2010b, p10). Hence, it is important to plan and implement appropriate strategies within pre-registered education to promote student nurses' cultural competence.

Adams and Gillman's (2017) systematic review of strategies to facilitate cultural competence from the pre-registered to registered period recommended three features: support, socialisation, and facilitated learning opportunities. There are a range of support programs and approaches to help develop cultural competence including Rush et al. (2013), and Adams and Gillman (2017). However, the consensus from above studies appears to be regarding the importance of support to facilitate practice skills development and the importance of positive workplace culture that encourages learning. Mentors and student nurses relationship was considered critical to the efficacy of the clinical placement experience (Burkaard et al., 2006; Constantin and Sue, 2007; Dressel et al., 2007) as it facilitates open discussion about cultural issues and strengthens the student nurses and mentors relationship (Constantine and Sue 2007, Dressel et al., 2007). However, whilst this relationship offers some insight into the development of culturally competent practice, the focus has been on the relationship rather than on the skills or the profession and finally acquiring the professional identity of "nurse" (Higgins et al., 2010; Whitehead et al., 2013).

Professional socialisation refers to the development of identity related to a particular occupation or role in which the skills, knowledge, beliefs and values of that profession are developed and internalised (Dinmohammadi et al., 2013). An individual identifies with the profession of nursing and defines themselves as “nurse” is initially influenced by learning and experiences within educational settings (Price, 2009). Acquisition of the values, beliefs and cultural norms of the nursing group is not static, it is dynamic and influenced by interaction with others (Horvat et al., 2014). Professional socialisation is a process that varies from person to person and is not necessarily linear as integration of this new identity requires change and adaptation and is continually renewed as part of life-long learning (Dinmohammadi et al., 2013). Understanding the values of the organisation and gaining acceptance by colleagues were “determinants of effective socialisation” (Phillips et al., 2013 p.120). An ethical practice climate that is culturally competent would effectively support nurses to develop their culturally competent practice (Loftin et al., 2013). Studies (Teal and Street, 2009; Gallagher and Polanin, 2015) also suggest that the skills acquired during educational preparation would develop incrementally with further training and a supporting workplace culture embeds the ‘knowing how’ of cultural competence.

Nursing is a culturally based profession in which trans-cultural knowledge and skills are essential to practice (Leininger, 1998). It is recognised that cultural education is critical to improve cultural competence in nursing. However, teaching cultural awareness remains a challenge in nursing education (Truong, et al., 2014; Kirkpatrick and Brown, 1999). Duffy (2001) states many approaches to cultural education, embedded in traditional anthropology and failed to acknowledge the global environment that impacts even the most remote and isolated cultures. Therefore, new, transformative approaches to cultural education are needed. Maiocco (1999) in a US study of emergency room and maternity care nurses indicated that culture was not included in their definition of competent care. Gerrish (2000) also reported from her study of district nurses in Britain that ethnicity was one of many variables considered in the provision of nursing care and its effect on care was limited. Nurses have a moral and legal obligation to provide quality care to patients and quality care includes culturally appropriate care. Additionally, universities have a social responsibility to prepare students who are learned and

caring citizens in multicultural communities. Increasing migration requires cultural education to be redesigned to meet multicultural demands.

Duffy's study (2001) revealed that cultural competence models and assessment tools guided students to learn descriptive information about others and to use that information to adapt care from the dominant culture, the western model of health care, to the individual patient from another culture. In a multicultural society cultures are no longer, to the degree they ever were, unique and impenetrable. Complexity reigns and its demands can be overwhelming. Hence, students are encouraged to be aware of their own cultural beliefs, attitudes, and feelings and subsequent impact of those on care in order to use that knowledge of self with a variety of nursing skills to adapt care to the patient's culture (Campinha-Bacote, 2002; Locsin, 2000). Duffy's critique of cultural education in nursing (2001) emphasises utilising students' critical self-reflection rather than focusing on distinct cultural characteristics. Self-reflection and awareness of one's own professional and personal culture is an important element of cultural competency (Campinha-Bacote, 2002).

It is suggested that a self-reflexive element is critical to cultural competency; cultural awareness alone is inadequate for addressing the effects of structural and interpersonal racism (Downing and Kowal, 2011). Contemporary culturally competent care training has been criticized for increasing stereotyping and reinforcing essentialist racial identities. Reflexive antiracism training is a promising alternative to cultural competent training. According to Duffy' study (2001), cognitive knowledge about each culture is less important than the ability to communicate, learn, and change. He claims critical reflection is necessary to evaluating the relevance of previous learning, including attitudes, behaviours, and knowledge to present circumstances. Although self-reflection is not without risk because individual beliefs and values are central to self-concept and to a consistent view of the world, self-reflection does not negate the need for traditional cultural knowledge. This transformative cultural education strategy encourages students to learn from single cultures to a broadened perspective, thus, students may be better prepared to provide culturally competent care in multicultural environment.

Another study of cultural competence in nursing education by Kozub (2013) concurs with Duffy's (2001) paper. The study describes using event analysis to explore

multiple perspectives of the nurse's experience, with the goal of transforming the nurse's approach to diversity from an ethnocentric stance, to one of tolerance and consideration for the patient's needs, values, and beliefs with regard to quality of care. The study shows a positive impact on promoting culturally competent nursing care. It encourages students to utilise critical reflection because it is at the core of the event analysis and involves awareness and analysis of one's own perspective and the role it has in the provision of culturally competent care. It also discusses the application of event analysis to multiple settings, including inpatients, educational, and administrative environment.

Hawala-Druy and Hill (2012) conducted a study in Howard University in the US using Campinha-Bacote's cultural competence theory as a conceptual framework to measure and evaluate pre and post culturally competent learning outcomes among healthcare profession students. Questionnaires and interview methods were used for data collection. Although it was a small mixed method study, its data collection was appropriate and analysis process was clearly justified. Results showed engaging in an interdisciplinary course that utilized eclectic and culturally congruent teaching-learning strategies that addressed and matched diverse learners' needs. In addition, students agreed that memorising multitudes of facts about a culture becomes less important than understanding, applying, and appreciating the cultural context of facts and importance of congruent individualised care. Furthermore, all students expressed the importance of understanding their own culture including bias and stereotype. The study has highlighted a positive impact on improving cultural competence through integrating cultural education in health care profession students' curriculum.

Cultural awareness requires practitioners to critically reflect upon their own conscious and unconscious beliefs and explore the impact of this on their interaction with patients (Cai 2016; Papadopoulos et al., 2016; Papadopoulos, 2006). Leininger (1993) states that without being aware of one's own cultural and professional values, there is a risk that the health care professional imposes his or her own beliefs, values, and patterns of behaviours on another culture. Health care professionals have been shown to have implicit race and skin tone biases. A lack of awareness has consequences for the patient-practitioner interaction (White-Means et al., 2009). Therefore, nurses need to be aware of the impact of their own assumptions

regarding particular groups and the potential impact of this when delivering care and interacting with patients (Papadopoulos et al., 2016; Teal and Street, 2009; Krauskopf, 2008).

The importance of this awareness and avoiding assumptions is also specifically mentioned in 1.3 of the Code (NMC, 2015), and this domain is consistent with cultural competence which requires the individual nurse to engage in reflection and "know yourself" (Doutrich et al., 2012 p.145). Similarly, cultural competence with its focus on self-awareness, open and egoless interactions requires an intensive approach to self-reflection and critique (Foronda et al., 2015). Obviously, it is impossible for nurses to learn everything about every culture. What is important is for all nurses to recognise that there are major cultural differences not only in the beliefs and practice of the patients they care for, but also in their need and expectations regarding care (Dayer-Berenson, 2014).

Having a substantive knowledge of all cultures is unlikely for student nurses; however, cultural knowledge usually develops as a consequence of increased interaction with patients (Douglas et al., 2014). This increase in both knowledge and skills occurs as a consequence of the cultural encounter, a central and pivotal concept within Campinha-Bacote's cultural competent care model. The model emphasises that knowledge is "the process of seeking and obtaining a sound educational base about culturally diverse base" (Campinha-Bacote, 2007, p.37). Obtaining cultural knowledge about the patients' health-related beliefs and values involves understanding their world view. The patient's world view usually explains how he or she interprets his or her illness and it often guides his or her thinking, doing and being (Campinha-Bacote, 2009).

In recognising that no one specific cultural competence model or assessment tool is the most effective in cultural teaching, some researchers (Hoffmann et al., 2005; Ruddock and Turner, 2007; Kemppainen et al., 2012) advocate multiple approaches to improve cultural competence among undergraduate nursing students. Calvillo et al. (2009, p.138) suggests that nursing curricula focus on acquisition of knowledge, skills, and attitudes of cultural competence, which is best attained "through a series of cumulative educational process". The careful planning of content in didactic courses with opportunities to apply this information in clinical practice is specifically

recommended (Sargent et al., 2005). Without specifically planned learning activities, cultural competency in an integrated approach is easily lost in the midst of other competing variables within the curriculum.

Teaching culture in an integrated approach is the most desired approach in the nursing literature. For example, Hoffmann et al. (2005) study used a unique collaborative experience between the University Of Pittsburgh School Of Nursing and the Miami Children's Hospital which offered nursing students the opportunity to complete one term of clinical experience in a culturally diverse health facility. The outcomes and evaluation of the collaborative program were based on feedback from the faculty, preceptors, Clinical Nurse Specialists, and students. This experience has effectively improved students' cultural awareness and competence level which enable them to practice in near future in the multicultural society.

Kemppainen et al. (2012) used international video conferences to promote students' cultural competence. It describes a highly successful, 10-year long international video conference exchange between nursing students in Iwate Prefectural University in Northern Japan and the University of North Carolina Wilmington in the US. They found these exchanges continue to promote nursing student learning regarding health care concerns, cultural health practices, and culturally competent care as well as a greater understanding of aspects of life as a nursing student in a country different from their own. Ruddock and Turner's (2007) qualitative study was conducted in Denmark. The study used a phenomenological approach and data collection was through in-depth conversational interview. It is a peer reviewed study, its methodology used was properly justified, ethical issues were explicitly discussed, and data analysis process was clearly described followed by interpretation of the data. As a result, the study result is credible and trustworthy. The findings suggest that cultural education is lacking, studying abroad programme helped to develop cultural competency in nursing students. The potential of the research is to inform the change of nursing education curriculum by adopting a studying abroad programme.

Cultural competence is recommended as a requirement to deliver individualised care upon nursing graduation, and yet, effectively teaching this concept to nursing students has been challenging. Nurse educators have been attempting to find new

approaches to improve culturally competent training over the years. In an attempt to determine the best approach for teaching cultural competence, Kardon-Edgren and Campinha-Bacote (2008) carried out a study in which four nursing curricula were compared. Two programmes based on Campinha-Bacote's theory, including cultural awareness, knowledge, skills, encounters, and desires. One program integrated culture throughout the curriculum without a specific theoretical approach, and the other program offered a two-credit culture class. The result showed no statistically significant differences in students' cultural competence regardless of the approach used. It was suggested that new technology would bring forward new ideas for cultural teaching. Inspired by this study's findings, Giddens et al. (2013) conducted a study that involved the collection of two surveys from 342 first-semester students from five baccalaureate nursing programs that used the neighbourhood virtual community during one semester. Results suggest that use of the virtual community may have contributed to cultural awareness and competence among nursing student participants and virtual communities may represent a useful teaching application for cultural competence in nursing education.

2.5.2 Interventions to improve cultural competency in health care settings

The review of existing literature includes a diverse range of populations (e.g. American, Scandinavian, British, and Asian), healthcare settings (e.g. hospitals, community centres, and academic medical/nursing settings) and interventions (e.g. cultural training programs for particular racial or ethnic groups, medical or nursing students).The majority of studies were carried out in the US, in contrast, very little UK based research has been done. Whilst the UK society is experiencing increasing diverse cultural population, nurses need to develop an understanding and awareness of culture in order to meet individual patient's need. The UK DH has advocated that the NHS will focus on personalised care, ensure that everyone, whatever their need or background, benefits from equality in access to health care. The NMC also made it clear that student nurses on qualifying should practise "in a fair and discriminatory way, acknowledging the differences and beliefs and cultural practices of individuals and groups" (NMC, 2004, p.27). Hence, this study is a valid investigation of student nurses' preparedness of cultural competency in the UK nursing training.

Many studies (Ali et al., 2016; Bennett 2009; Bench et al., 2005; Cavillo 2016; Campinha-Bacote, 2010; Carpenter and Garcia, 2012; Dayer-Berenson, 2014; Diaz and Clarke, 2015; George et al., 2015; Henderson et al., 2011; Long, 2012; Papadopoulos, 2016; Quickfall, 2014; Truong et al., 2014; Ruddock and Turner, 2007) focus on educational and clinical interventions in order to develop nurses' cultural competence. Those interventions are lectures, group discussions, cases studies, overseas learning, clinical and community learning experience, and reflective exercises. These studies demonstrated that based on either a self-report or self-reflection method, following the interventions, student nurses had an increased level of cultural competence. However, it is arguable that more robust methods rather than the self-report method might be more credited for evaluation of the intervention effectiveness.

The literature review has identified a number of key issues and limitations about what is currently known about interventions to improve cultural competence within health care settings. The interventions used, patient populations, health care professional populations and outcome of interventions are heterogeneous. This reflects the complexity of the area and its application into practice and research. European Psychiatry Association (EPA, Schouler-Ocak et al., 2015) guidance on cultural competence training has highlighted that cultural competence can be achieved through individual and organisational efforts. They suggested that interactive lectures and role play along with small group work can help students understand the most effective ways of doing things and engaging patients; reflective practice is essential to achieve cultural competence; and organisations must measure outcomes of cultural awareness and competency. Overall, most studies report positive outcomes through interventions. However, it remains unclear what intervention is most effective, in what context, for whom and why. The lack of uniformity in terminology and definition reflect the many variations of terms and definitions used in relation to cultural competence at present. This is likely a key contributing factor to the lack of consensus to develop, implement, and evaluate cultural competency interventions (Truong et al., 2014). Campinha-Bacote's (2002) model of cultural competence has been utilised as measure for pre and post cultural competence learning outcomes (Hawala-Druy and Hill, 2012), and its result showed integrating the five elements (cultural awareness, cultural knowledge, cultural skill,

cultural encounters, and cultural desire) as teaching-learning strategy has improved learners' cultural competency level. Integrating cultural competence education into student's curriculum proves to be effective to develop cultural competence.

Studies that examined patient outcomes following cultural training interventions found some improvement in health outcomes (Lie et al., 2011; Hawthorne et al., 2008; Chipps et al., 2008; Whittemore et al., 2007). However, there were some limitations among these studies. For example, although Hawthorne et al. (2008) study focused on cultural education for diabetic patients and found short-term (up to one year) effects on blood sugar control and knowledge of diabetes and healthy lifestyles, long term effects were not included in the study. Similarly, Whittemore et al. (2007) study critically examined culturally appropriate interventions in relation to diabetic patients, the results showed significant improvement in behaviour changes and diabetic knowledge, but only among Hispanic populations. Chipps et al. study (2008) also revealed increased patient satisfaction through cultural trainings among health care professionals. It is echoed by another study's findings (Lie et al., 2011), which demonstrated positive relationships between cultural competency training and improved patient outcomes.

Kagawa-Singer and Kassim-Lakha's study (2003) provides an anthropological perspective of the fundamental relationship between culture and health. The study outlines systemic changes needed within the social and legal structures of the health care system to reduce the risk of cross-cultural miscommunication and increase the likelihood of improving health outcomes for all populations within the multicultural US society. The authors define the strengths inherent within every culture, provide a guideline for the clinician to evaluate disease and illness within its cultural context, and outline the clinical skills required to negotiate amongst potential differences to reach mutually desired goals for care. The study advocates the desired level of practice for culturally competent expert is a bicultural or multicultural status. In other words, the health care professional is expected to be sufficiently knowledgeable about his or her own culture as well as about one or more other cultures of patients that he or she treats to recognize the differences, understand what they mean, and bridge those differences to accomplish clear and effective communication of information and caring. The study findings also indicate the structural changes required in the health care setting to enable and support such practice. The study

demonstrates that culture is fundamental to the development and management of disease in every population, for its purpose is to teach its members what to do to survive, how to do it, and why they should persevere in the face of adversity. As such, physicians would benefit themselves as well as patients by learning how to be culturally competent in the delivery of medical care.

One of the aims to raise cultural competence is to improve patient outcomes, thus patients' perceptions are important to determine how culturally competent health care professionals are. However, only one study (Johnson et al., 2004) focused on patient's perception of cultural competence was published. It was involving a total of 6299 adult patients who identified as white, African-American, Hispanic, and Asian adult patients in a primary care setting. The report addresses the participants' perceptions of their primary care providers' and health care system-related bias and cultural competence. The strength and unique contribution of the study is that it explores cultural competence from the patients' perspective. Involving patients in the research may help health care professionals recognise patients' perceptions from different cultural background so appropriate approaches and adjustment could be used as health care providers.

Critics have suggested that current focus on multiculturalism actually increases the distance between cultures because of its acknowledgement of the superficial and failure to address underlying social condition (Kraeh et al., 2016); and also issues of cultural acceptance and integration (Iyer, 2000). Studies (Riemenscheider et al., 2016; Kraeh et al., 2016) suggest that socio-cultural factors play an important role in improving health status and health-promoting behaviours. For example, a multi-centre cross-sectional survey (Riemenscheider et al., 2016) was conducted in Germany and Hungary. The sampling strategy was clearly described and justified. The large scale study included international medical students (n=2935) in their first year, third year, and fifth year by using mixed method. The analysis was based on students' self-reported data through questionnaires. The data collection and analysis process were rigorous and sound which supported validity of the findings. Results showed those who were in better socio-cultural status such as financial situation did a lot more for their health. The strength of this study is that from socioeconomic perspective, it highlights the importance of socio-cultural factors for promoting health and wellbeing, however, the methodology used in the study lacks sufficient rigor. The

authors argue that situational prevention and corporate social responsibility should be highlighted further to support health promoting behaviours. Additionally, they advocate that an obligatory, free-of–charge course for health promotion activity or relaxation should be included in medical student's curriculum for all students; this could help students to cope with the high requirements of medical studies and foster long-lasting health effects affecting the health of future doctors and directly their patients.

Consideration of social context as a factor that influences cultural competence has also been emphasised in a study conducted in Saudi Arabia (Almutairi et al., 2015). This study used semi-structured interviews of 24 non-Saudi nurses. Data collection and analysis were undertaken drawing on Campinha-Bacote's cultural competence model. They found those non-Saudi nurses within this culturally diverse environment struggled with the notion of cultural competence in terms of each other's cultural experiences and those of the dominant Saudi culture. The findings emphasize that in a Saudi context, cultural competence requires a combination of individual desire and efforts to learn coupled with adequate organisational support and resources. This study addresses that cultural competence in multicultural context can only be achieved through continuous professional education and training not only at an individual level, but also with adequate organisational level of support.

Truong et al. (2014) also suggest that interventions to improve cultural competency need to consider the individual and organisational contexts and interplay between them. It is likely that cultural competent care training as a stand-alone strategy is insufficient to improve patient outcomes without concurrent systemic and organisational changes (Srivastava, 2008). Hence, planning and implementation of cultural competency interventions should acknowledge the interaction between an intervention and the context. Organisational cultural competence involves an understanding of the strengths and weaknesses of the healthcare organisation and the unique needs of the people it serves (Williams, 2011).

In order to help the global migration of nurses to meet demands of caring for patients with different cultural backgrounds, the document of "*Guidelines for Implementing Culturally Competent Nursing Care"* was developed by a collaborative task force of members of the American Academy of Nursing (AAN) expert panel on Global

Nursing and Health And Transcultural Nursing Society (Douglas et al., 2014). The aim of this document is to present universally applicable guidelines for implementing culturally competent care, and serve as a resource for nurses in various roles including clinicians, educators, administrators, and researchers. However, it should be used appropriately in relation to the socio-cultural context and unique health care delivery system of the user. There are ten elements of guidelines in the document (see Appendix 5). They are: knowledge of culture, education and training in culturally competent care, critical reflection, cross-cultural communication, culturally competent practice, cultural competence in health care systems and organisations, patient advocacy and empowerment, multicultural leadership, and evidence-based practice and research (Douglas et al., 2014). This document emphasised multi-faceted efforts for developing student nurses' cultural competency which include education institutions, health care systems and leadership, patients' voices, and individual student's critical reflection of cultural values, behaviours and attitudes. It is recognised that developing cultural competence is a process which needs to be congruent throughout the nursing education in institutions and clinical settings.

Whilst the UK NHS focuses on equity, the reduction of health inequalities and countering racism, the US system have historically paid less attention in terms of universal health care coverage (Coker, 2001). Furthermore, minority ethnic groups are known to be more likely than whites to perceive bias and a lack of cultural competence in US health care provision (Johnson et al., 2004). Hence, one can argue the application of US cultural competence models to the UK might be limited due to major differences between the two health care systems. However, educational preparation and clinical practice for nurses in the UK has undergone substantive change. In addition, nursing roles, responsibilities, and workplace settings have also experienced and continue to experience transformation (Lima et al., 2016) and will continue to do so. Although the guidelines may not be fully transferrable, relevant or applicable to the contemporary UK nursing practice, considering the guidelines did void some guidance that were developed on the basis of existing evidence on cultural competence worldwide, it can be amended according to specific health care system, in particular areas of cultural knowledge, cultural training, critical reflection on cultural competence, and cross-culture communication have demonstrated good clinical outcomes. Hence, with appropriate amendments,

these guidelines are potentially adaptable for implementing culturally competent nursing care in the UK. This study is intended to examine the student nurses' preparedness of cultural competence in their nursing training for delivering culturally competent care upon graduation. Given the fact that the guidelines are universally applicable with appropriate modification, the majority of contents in the guidelines could be potentially transferrable to the UK nursing education and assessment of student nurses' cultural competence.

2.5.3 Terminology used in literature and its impact on cultural assessment

The pioneer transcultural nursing theorist Leininger (1991) developed theory of culture care delivery and universality with primary focus on integrating culture into nursing care. In this theory, cultural competence was described as a skill set that enables health care professionals to respectfully elicit from the patients and families information needed to make an accurate diagnosis and negotiate mutually satisfactory goals for treatment. Many cultural competence models were later developed to translate this theory into nursing practice and to present factors that could influence the phenomenon of care (Giger and Dvidhizar, 2002; Purnell, 2002; Capinha-Bacote, 2002). Of these practice models, Campinha-Bacote's model of five components has been most cited in the scientific literature which describes cultural competence as "the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family and community)" (Campinha-Bacote, 1999; p. 203).

Despite on-going efforts to integrate a cultural perspective in health care system, definitional issues had hampered conceptual and empirical progress in the field (Fuertes and Gretchen, 2001; Lakes et al., 2006). Although there is general consensus that cultural competence broadly requires awareness of culture and application of this knowledge to diverse cultural backgrounds of patients (Betancourt et al., 2003; Whaley and Davies, 2007), the literature still lacks a clear, uniform definition, and key terms continue to be used interchangeably. For example, scholars have referred to interventions that are modified to accommodate the beliefs, attitudes, and behaviours of culturally diverse patients as culturally adapted, culturally sensitive, culturally responsive, and culturally competent without much

distinction (Whaley and Davies, 2007). In addition, cultural competence models and frameworks differ in their utilisation specialities, and most of the studies focus on post-graduate level training. Such variations make evaluating the impact of cultural competence in the context of health care systems challenging. Cultural competence has been embedded in professional accreditation standards internationally, and some studies have identified beneficial effects of cultural competence on health care professionals' cultural knowledge, attitudes, and skills, and on level of patient satisfaction (Bhui, et al., 2007; Cabral and Smith, 2011; Ceballos et al., 2010). Very few have explored cultural competence training on pre-registered nursing students.

Furthermore, despite the recognition of culturally competent care delivery as an essential part of nurses' role, there is no clear indication being given on how to ensure student nurses became more knowledgeable and aware of different cultural needs of patients in the UK (Holland and Hogg, 2010). Cultural competence training aims to improve the quality of health care and reduce health disparities by focusing on communication and trust between patients and health care providers. It also aims to enhance provider knowledge about socio-cultural factors linked to health beliefs, practices and utilisation of services (Betancourt et al., 2003). A nurse who does not recognise the value and importance of culturally competent care cannot possibly be an effective care agent in this changing demographic society (Gigger, 2016).

As previously illustrated, cultural competence consists of two sub-concepts, culture and competence, its definitions vary depending on which component is in focus. With culture in focus, the domains of culture are presented specifically as cultural values, beliefs, and practices; with competence in focus, the characteristics of competence may be manifested explicitly as cultural awareness, knowledge, and skills. While debates exit due to the different focus of 'culture' or 'competence', some researchers recognised cultural competence as a continuous, developmental, evolutionary, evolving, and dynamic process (Jeffreys, 2010; Giger and Davidhizer, 2004, Campinha-Bacote, 2002; Papadopoulos and Lees, 2001). What constitutes the definition or meaning of cultural competence, including such domains as cultural knowledge and skills are not static or finite and will change in response to the needs in the changing demographic and cultural context. This perspective may help healthcare educators and professionals to recognise that cultural competence is a

dynamic, continuous, and developing process (Campinha-Bacote, 2002) in providing culturally integrated and competent health care for culturally diverse populations.

Cultural skill is the ability to perform accurate holistic health assessment, especially when performing physical examination on ethnically diverse patients, one should be aware the differences in body structure, skin colour, and laboratory variances (Campinha-Bacote, 2009). While the importance of practice skills are commonly cited within frameworks discussed in the literature on pre-registered nursing (Allen, 2010; Jirwe et al., 2009; Krainovich-Miller et al., 2008), explicit examination of practice skills remains limited. The paucity of research into practice skills is a likely consequence of conceptual differences and ambiguity in terminology discussed previously. If there is no clear consensus as to a definition or clear operationalization of terms, then its application to nursing practice and patients' experience of health care is likely to prove challenging and not feasible.

However, there are two key areas in relation to the skills that are recurrent themes with all models of cultural competence; cultural assessment and communication skills. Leininger (2002) encourages health care professionals to conduct a holistic "culturalogical" assessment and included biological, psychosocial, economic, educational, environmental and political and/or economic factors. This multiple level of factors are applied by the nurse to maintain, accommodate or re-structure a patient's health, care and lifestyle in a way that is meaningful for them (Leininger 2002). Similarly, both Campinha-Bacote (2002) and Papadopoulos (2006) interpret cultural skills as requiring the nurse to incorporate cultural data into the assessment of patient needs.

Whilst cultural assessment as a framework or assessment tool for determining patient needs appears to be prevalent in the US, it has not been implemented in the UK (Holland and Hogg, 2010). This is not to say that assessment of cultural needs does not occur, however, the extent to which assessment and care planning in the UK meets the criteria for a holistic "culturalolgical" assessment as advocated by Leininger (2002), Campinha-Bacote (2002) and Papadopoulos (2006) can be questioned. A study of practising nurses in Sweden (Jirwe et al., 2009) found that healthcare professionals were less likely to consider ethno-history as important when compared to academics or researchers despite the fact that cultural assessment was

considered essential to care planning (Douglas et al., 2004). A number of studies (Andrew and Boyle, 1999; Sealey et al., 2006) have been published on the importance of considering patient's culture as an integral part of assessing their health needs and planning culturally appropriate nursing care. For instance, if nurses are assessing the health and nursing care needs of the patients, they need to be more sensitive to the way the patients communicate to them and also the communication skills they use to speak to patients. Depending on the individual patient's cultural background, some patients may perceive certain non-verbal communication skills such as looking directly into the patient's eyes as aggressive or rude. Similarly, some nursing interventions, such as hugging the patients may be perceived provocative, aggressive and rude by some cultures and the patients may react in distressful ways that could be misunderstood by nurses as signs of depression. It is, therefore, important for nurses and other health care professionals to gain knowledge about diverse cultures and the degree of acculturation of the individuals by integrating assessment of their cultural needs into nursing care planning.

Cultural assessment seeks to determine the cultural practice, beliefs and preferences of the individual patient and then incorporate these into the plan of care. Undertaking a formal clinical assessment requires the nurse to have a considerable level of awareness, sensitivity, and knowledge which may be outside of the competency range of most pre-registered nurses upon qualification. According to Campinha-Bacote (2011) the cultural encounter provides the nurse with an opportunity to interact with patients from different cultural backgrounds and develop cultural desires, awareness, skills, and knowledge. However, the skill of cultural competence could also be seen as active application of the domains of cultural desire, awareness, skill, and knowledge to the patient encounter. Leininger (2002) specifically considered care and caring as central to cultural competence and this was an action that took into account individual differences (the beliefs, values and modes of care). The action that the nurse takes in response to a culture can be seen to be an application of their knowledge, awareness, and skills to this interaction, with this patient, and in this context.

Campinha-Bacote's (2011) additional work in the field of cultural competence has linked assessment skills with the ability to collect cultural data in order to deliver

patient centred care. Saha et al. (2008) argued that advocates of cultural competence see their construct as one aspect of patient centred care, whereas proponents of patient centred care assert the opposite. There is evidently overlap between these two and both are concerned with improving care quality (Zhao et al., 2016). The key difference is that cultural competence has placed a greater emphasis on addressing health inequalities as challenging discrimination, although this is not always explicit in some models.

Communication continues to be advocated as the most important skill in cultural competence which is consistent with requirements for professional nursing practice in the UK (NMC, 2014; 2015). Effective patient-practitioner communication improves patient satisfaction with healthcare (Chang et al., 2013) and enables nurses to transfer their knowledge, awareness and skills into cultural competent care practice. Although all nurses are trained in communication skills, competence and confidence in communicating with patients from diverse backgrounds is required which facilitates preventing cultural misunderstandings (Kai et al., 2007; Jirwe et al., 2009; Teal and Street, 2009).

The dominant discourse in relation to communication appears to be about barriers and challenges when there is no shared language proficiency between nurses and patients (Ali and Johnson, 2016; Hart and Mareno, 2014; FRA, 2013; Chang et al., 2013). Language difficulties are key barriers for marginalised and/or disadvantaged groups in terms of accessing and receiving healthcare (Ali and Johnson, 2016; Douglas et al., 2014; EHRC, 2010). When language proficiency is not shared, translation services or an interpreter may be a more effective way of communicating (Cai, 2106), or the use of bi-lingual colleagues (Ali and Johnson, 2016). Although using patients' families and friends as interpreters for the patient is not advocated in practice because of potential ethical conflicts, this appears to be a common occurrence (Jirwe et al., 2009).

Communicating in a culturally competent way requires sensitivity to both verbal and non-verbal communication cues, of the patient as well as the nurses own (Krauskopf, 2008). The literature has tended to focus habitually on language barriers rather than an understanding of the range of verbal, linguistic or communication skills and behaviours that comprise 'cultural fluency' in communication (Mor Barak, 2005).

Allen (2010) has argued that transcultural nursing has been privileged in the nursing literature and this may have created an emphasis on race, ethnicity and religion. However, there has been an increasing recognition that cultural competence needs to go beyond ethnicity, religion and race and overcome language barriers (McGee and Johnson, 2014).

Cultural desire arguably plays a key part in driving the development of culturally competent practice and has been seen as a precursor to other components (Issac et al., 2016) or antecedent (Cai, 2016). Without cultural motivation or desire, then cultural awareness, knowledge, and skills may not develop. However, cultural desires or motivation appears to be the least developed among five constructs. Issac et al.'s (2016) study found that although student understanding of aboriginal health increased after completing a specific model of cultural competence, their overall cultural desire did not. The study concluded that this was because cultural desire might take time to develop. However, if this takes time to develop it questions the validity of arguments positioning cultural desire as a precursor or antecedent to awareness and knowledge.

Similarly, 'cultural humility' (Foronda et al., 2015) and 'cultural safety' (Doutrich et al., 2012) represents an explicit and direct paradigmatic shift. Representing a movement away from a focus on domains related to demonstrating skills, competencies and behaviour, these frameworks start with individual practitioners' values, beliefs, and assumptions. These are challenged, developed and enhanced through a process of self-critique and examination and commitment to reflection and life-long learning. In effect, both cultural humility and cultural safety are consistent with core attributes in traditional models of cultural competence such as sensitivity, humility, awareness and desire. With a limited and inconclusive evidence base to link cultural competence training or education with better outcomes (Henderson et al., 2011; Lie et al., 2013; Horvat et al., 2014), discussion of cultural competence appears to be moving away from a focus on competence and proficiency to self-reflection. Competence assumes an end outcome that is achievable whereas cultural humility encourages a process of on-going learning, reflection and personal growth and development (Foronda et al., 2015).

Many terminologies were interchangeably used in literature which caused somewhat confusion and misunderstanding. In this study, Campinha-Bacote's cultural competence theory and its five components including "cultural awareness", "cultural knowledge", "knowledge skills", "cultural encounters", and "cultural desire" were the key terminologies used.

2.5.4 The impact of cultural competence care models in literature

Whilst the dominant theory of transcultural nursing is based on the pioneering work of Madeline Leininger (1991), there are other three recommended cultural competence models in nursing literature. They are Purnell's model (2002); Campinha-Bacote's model (2002); and Gigger and Davidhizar's model (2008). These models provide systematic approaches to nursing education and practice but with different focus. Each model has its strength and areas of focus as table 3 illustrated. Papadopoulos (2006) suggests the four key cultural competence models have and will continue to play a crucial role in making nursing practice more effective and efficient. However, despite their positive contributions, the cultural competence models have been recognised for their limitations and failure to acknowledge issues related to educational and practical components of nursing (Raman, 2015). The strength and limitations of the four key models are explored in the following paragraphs.

Table 3: Key Models of Cultural Competence

Cultural Competence Models	Focus
Leininger's sunrise model	Enable nurses to identify patients' values, beliefs and behaviours.
Purnell's model	Provides a foundation for understanding the various attributes of different culture; allows nurses to adequately view patients 'attitudes about health and illness.
Giger and Davidhizar's model	Focus on communication, space, social organisation, time, environmental control, and biological variation.
Campinha-Bacote's model	Emphasis is not only on one factor but a process including five steps: cultural awareness, knowledge, skills, encounter and desire.

A Health Resources and Services Administration (HRSA, 2001) study identified two approaches, theoretical and methodological, adopted to conceptualizing cultural competence in the literature. Cross et al. (1989) and Campinha-Bacote (1999) took a theoretical approach in which cultural competence is seen as a process. On the other hand, Leininger (1993), and Davidhizar and colleagues (1998) offered a methodological approach that focuses on the methods that health care professionals might use in order to become culturally competent. Leininger (1993) states that without being aware of one's own cultural and professional values, there is a risk that the health care professional imposes his or her own beliefs, values, and patterns of behaviours on another culture.

Leininger's Sunrise model (1991) connects the concepts of the theory with actual clinical practices, while offering a systemic approach to identifying values, beliefs, behaviours, and community customs. The model encompasses numerous aspects of culture: religious, financial, social, technological, educational, legal, political, and philosophical dimensions. Whilst the strength of the model is its clear and simple way for evaluating professional and societal cultures (Higginbottom, et al. 2011), it has been critiqued for failing to acknowledge political and structural processes. Critics have argued that it focuses exclusively on cultural diversity, biases, conventional views, and the inequity between nurses and patients. According to these critiques, the model also fails to acknowledge that cultural diversity needs to go beyond between group differences and be understood from the perspective of differences among individuals from the same culture, due to varying socioeconomic backgrounds, age groups, and types of communities (Albougami, et al., 2016).

Giger and Davidhizar take an approach that is different than Lininger's Sunrise Model, arguing that not every individual of the same culture or ethnicity behaves in the same manner. Giger and Davidhizar's model (2008) has six dimensions common to every culture: communication, space, social organization, time, environmental control, and biological variation. The model was initially used for helping student nurses provide and assess health care for individuals from diverse cultural backgrounds, later used as a framework that enables nurses to assess culture's role in health and illness. It can also serve as an academic and clinical framework for developing cultural competence. However, the concerns were around tact and

boundaries of these six components when conducting the assessment to avoid causing unnecessary anxiety of the patient (Gigger and Davidhizar, 2008).

Purnell's model (2002) is a framework that can be employed to incorporate transcultural competence into nursing practice. Flexibility is one of the strongest features of the Purnell model, enhancing its applicability in various healthcare contexts (Albogami, et al., 2016). Moreover, the model's healthcare framework allows nurses to learn the different characteristics and concepts of cultural diversity, and encourages nurses to consider and reflect on the unique characteristics of every patient, including their views of illness, motivation, and health care.

Whilst Purnell's model draws broader perspective, which makes it more applicable to all healthcare environment and practice discipline, Cambinha-Bacote's (2002) model of cultural competence has been appraised to be more comprehensive, logical and have better clinical utility (Brathwaite, 2015). The five components (cultural awareness, cultural skills, cultural knowledge, cultural encounters, and cultural desire) that build upon one another in a logical progression, providing concise outcomes for interventions, a clear description of processes, and an immediate clinical benefit in optimizing patient care planning (Amerson, 2010). Furthermore, the model has been most often used as a framework for research and practice.

As previously discussed in defining cultural competence, there are different focuses between the two aforementioned approaches. The theoretical models appear to have the competence component in focus, manifesting the competencies of awareness, knowledge, sensitivity, and skills as the domains. The methodological models are likewise focused on the culture component, manifesting the aspects of religion, ethnicity, healing beliefs, practices, and value orientation as the domains. As both types of models place an emphasis on only one component of cultural competence with its domains presented explicitly, the characteristics of the other component remain abstract. Hence, no single cultural competence care model can apply for all cultures. Andrews and Boyle (2012) suggest that in combination of cultural skills and critical thinking ability, cultural competent care may be achieved for patients from variety of cultural backgrounds, rather than simply memorising the esoteric health beliefs and practices of any specific cultural group.

Although those cultural competence models have a different focus on service delivery for diverse cultural patients (please see table below) they helped make nursing practice more effective and efficient to some extent over the decades. Models (Leininger's sunrise model, 1991; Purnell's model, 2002; Giger and Davidhizar, 2008) derived from predominantly a United State (US) perspective have also been applied and used within nurse education, nursing practice and health care settings across the world (Loftin et al., 2013; Douglas et al., 2014; Polanin and Gallagher, 2014). It suggests however, that these cannot be applied to the UK experience without modifications as there are differences in focus between countries. US and UK models have tended to consider cultural competence as being concerned with interaction between nurses and patients from different cultural background (Jirwe et al., 2009), recognising the central role of caring and care to this relationship (Leininger, 2002). Whereas, New Zealand takes a broader view that all encounters between nurses and patients are in effect cross-cultural (Foronda et al., 2015).

In addition, the emphasis placed on anti-discriminatory practice and the responsibility of the nurse to challenge this varies between countries and models (Jirwe et al., 2009; Foronda et al., 2015). Papadopoulos et al. (2006) state the ability to recognise and challenge discrimination and oppressive practice is fundamental to the delivery of culturally competent care, and explicitly linked to health inequalities and the human rights agenda. Authors do however appear to be in agreement that cultural competence can best be understood as a process (Campinha-Bacote, 2002; Loftin et al., 2013) although it has been associated with the notion of outcome (Bhui et al., 2007). There seems to be no compelling reason to argue that cultural competence is an outcome, however the very nature of the term "competence" assumes that this is something achievable that one can become proficient in. That is the process of acquiring cultural competence has an end result-that of being a culturally competent practitioner. The development of the skills and abilities of culturally competent practice are evidently incremental (Teal and Street, 2009), and have synergy with the notion of graduated competency in pre-registered nurse education in the UK (NMC, 2014).

However, whilst some nursing competencies can be measured, cultural competence is significantly complex and multi-faceted. It is better understood as "an active

process of learning and practising, this evolves over time and requires a constant commitment" (Cavillo et al., 2009; p.140). The evolution of cultural competence, changing terminology, lack of operational clarity and limited consensus as to preferred terms has negatively affected its potential for measuring impact on patient care (Horvat et al., 2014; Loftin et al., 2013). The lack of reliable outcome measures to evaluate and research the impact of cultural competency has been persistently reported in the literature (Loftin et al., 2013; Olt et al., 2010; Krainovich-Miller et al., 2008). Where measures have been developed they have tended to be primarily self-reported instruments. For example, Campinha-Bacote's Inventory for Assessment of the Process of Cultural Competence among Health Care Professionals IACCP-R (revised); and Kardong-Edgren and Campinha-Bacote (2008), used with mainly student populations and relied primarily on convenience sampling (Loftin et al., 2013). Additionally, the self-report measures assume that the person who is best placed to determine whether they are culturally competent or not are the individual nurses rather than the patient. Patient perspectives on cultural competence is recognised as a limitation of research within the field (Shen, 2015; Chang et al., 2013; Jirwe et al., 2009), and the lack of impact on health outcomes a likely consequence of this (Loftin et al., 2013).

Of those cultural competence models, Campinha-Bacote's model (2002) has been most utilized to measure and evaluate pre and post culturally competent learning outcomes among healthcare professional students, and recommended to be used as a framework in all health care settings including clinical, administration, research, policy development, and education. The five constructs of the cultural competent care model have interdependent relationship with each other, and no matter when the healthcare professional enters the process, all five constructs must be addressed and experienced. It views cultural competence is an on-going process which involves the integration of the five components.

As previously stated that Hawala-Druy and Hill's study (2012) used Campinha-Bacote's model as a conceptual framework to measure and evaluate healthcare professional students' level of cultural awareness and competence pre and post the education intervention. It suggested that Campinha-Bacote model (2002) is sufficiently comprehensive to guide empirical research and the development of educational interventions. It can be used as a training and assessment tool at any

healthcare settings and educational institutes. The study results demonstrate engaging in an interdisciplinary course that utilized eclectic and culturally congruent teaching-learning strategies addressed and matched diverse learners' needs. Furthermore, the study points out that memorising multitudes of facts about a culture becomes less important than understanding, applying, and appreciating the cultural context of facts and importance of congruent individualised care. The study findings also indicate the importance of understanding of students own culture including bias and stereotype. The study has demonstrated a positive impact on improving cultural competence through integrating cultural education in health care profession students' curriculum.

The use of Campinha-Bacote's cultural competence model (2002) for the study provides evidence of improving student's cultural competence. The model's five components are particularly logical and integrated well throughout the process of becoming culturally competent, and can be used to strengthen the cultural competence of nurses practicing in countries all over the world (Albougami et al., 2016). Therefore, this study adopted Campinha-Bacote's cultural competence model as a framework to critically examine student nurses' preparedness of cultural competence in their nursing training, institutionally and clinically. The findings are hoped to provide some insights into student nurses' experiences of cultural competence, institutional and clinical factors impact on student nurses' cultural competency, and recommendations from student nurses' perspectives on developing cultural competence.

2.6 Identification of key gaps in the evidence base

The literature review has identified a number of key issues and gaps in the evidence base which warrant further investigation. Although there is general consensus that cultural competence broadly requires awareness of culture and application of this knowledge to diverse cultural backgrounds patients (Betancourt et al., 2003; Whaley and Davies, 2007), the literature still lacks a clear, uniform definition, and key terms continue to be used interchangeably. Cultural competence models and frameworks differ in their utilisation specialities, and most of studies focus on post-graduate level training. Such variations make evaluating the impact of cultural competence in the

context of health care system challenging. The different definitions of culture and cultural competence; the existence of multiple cultural competence theories; and how to integrate theories into education and practice are the challenges that health care professionals have to face when developing cultural competence.

Many US based studies (Cabral and Smith, 2011; Ceballos et al., 2010; Fitzgerald et al., 2009; Campinha-Bacote, 2010) have showed improved outcomes of integration of cultural training into nursing education curriculum; little research has explored cultural competence training among pre-registered nursing students, particularly in the context of UK society. Omeri's study (2008) focuses on the context of nursing practice within diverse cultural societies such as the UK. The result reveals a lack of formal, integrated cultural education into nursing. Furthermore, despite the recognition of cultural competent care delivery as an essential part of a nurse's role, there is no clear indication being given on how to ensure student nurses became more knowledgeable and aware of different cultural needs of patients in the UK (Holland & Hogg, 2010). Campinha-Bacote's (2002) five elements of cultural competence have been recommended to be used as a framework to train and assess cultural competence, and it, particularly is applicable to nursing professionals. However, there remains a lack of its utilisation in the UK nursing education and practice. The lack of available research evidence that specifically addresses UK student nurses' preparedness and practice of cultural competence would lend support to the argument that this is underexplored in the literature, and represents a distinct and unique topic area.

2.7 Summary

The literature review revealed four key issues. Firstly, educational preparation may have provided sufficient opportunities to develop some but not all knowledge and skills required in the code (NMC, 2015) or considered pertinent to cultural competence (Douglas et al., 2014). The UK professional guidance in relation to respecting individual differences and valuing diversity has tended to be primarily prescriptive without a clear statement on doing and how it 'looks like' in practice.

Secondly, whilst a wealth of papers published in the US have shown the improvement of cultural competence by using Campinha-Bacotes' model as a

framework, the number of UK based studies on cultural competence among nurses is limited. In addition, how to implement cultural competence in nursing training and practice remains uncertain.

Thirdly, the concept of culture and cultural competence is somewhat confusing due to hybridity of the nature of culture. There is no uniform definition of culture and cultural competence that has been accepted across the spectrum of health care settings or contexts. Many terms have been used interchangeably such as “cultural competence”, “cultural safety”, “cultural sensitivity”, and “cultural responsiveness”. This lack of uniformity of terminology is likely to be the main factor to the lack of consensus on the best way to develop, implement, and evaluate cultural competency interventions (Truong, et. al., 2014).

Finally, it is difficult to determine which cultural competence care model is the best to use in health care context because studies showed many potential outcomes from variety of models used. Although Campinha-Bacote’s model of cultural competence has been most cited and used as a framework worldwide, other models also raised the awareness and understanding among all the health care professionals of the importance to improve cultural competence. The evidence of most effective model and tool to use in the health care settings is relatively weak.

This deficit in information from the nursing literature has raised my research questions: what is the UK student nurses’ cultural competency, and does this equip them to deliver culturally competent care when providing care to patients from diverse cultural backgrounds? This study has provided a unique opportunity to critically examine student nurses’ preparedness of cultural competence through exploration of their own perceptions and experiences of delivering culturally competent care in clinical settings. It has also set out to seek views on institutional and clinical factors impact on student nurses’ cultural competence and student nurses’ recommendations on the development of cultural competence. By using qualitative data analysis of cultural competence training and clinical experiences, the findings are hoped to contribute to the understanding of support required from HEIs and health care settings to enable student nurses’ cultural competency upon graduation.

Chapter 3: Research methodology

3.1 Introduction

The literature review chapter has shown that whilst a significant amount of research in the field of cultural competence exists worldwide, there remain gaps in the evidence base in terms of student nurses' preparedness for delivering culturally competent care upon graduation in the context of UK society. These gaps subsequently informed the research question, methodology, and design for this study.

This chapter outlines the philosophical and qualitative methodological perspectives that formed the study, from which ontological and epistemological stances informed the research design presented. The process of research conduction is explicitly illustrated including recruitment strategy and process, sampling process, data collection and analysis. Quality assurance and ethical issues of the research are addressed, which provide rationale regarding why phenomenological approach was chosen and how the research had been carried out.

3.2 Research question

As stated in chapter 2, the key questions for this study are: What is student nurses' cultural competency when providing care to patients from diverse cultural backgrounds, and are they equipped for delivering culturally competent care in clinical practice?

The key questions emerged from informed understanding of the topic area, evidence base, and literature review which represented specific elements of the inquiry that warranted further investigations. The existing gaps in the evidence base as argued in chapter 2 supported generating further knowledge and insights into preparedness of cultural competence among student nurses from one of the London universities.

The aim of this study is to critically examine student nurses' preparedness in their nursing training for delivering culturally competent care upon graduation. In order to meet this aim, the following three objectives are generated to carry out the study:

1. To critically explore student nurses' perceptions and experiences of cultural competence.
2. To identify factors of institutional and clinical nursing training impact on student nurses' cultural competence.
3. To offer recommendations for the progressive development of cultural competence from student nurses' perspectives.

3.3 Research design and methodology

Methodology refers to more than just the methods used to undertake a study. Specific reference should be made to the concepts and theories that underpinned the method chosen. Methodology then can be described as "a bridge between theory (ideas) and method (doing), offering consistency and coherence throughout the entire research process" (Kramer-Kile, 2012, p.27). Research is divided into two paradigms; quantitative and qualitative research. There are differences between these two types' researches (Guba and Lincon, 1994; Taylor et al., 1995). In qualitative research, the author intends to describe a research problem that can be best understood by exploring a concept or phenomenon; whereas in a quantitative research, the problem is best addressed by understanding what factors or variables influence an outcome (Creswell, 2014).

This study intended to examine student nurses' preparedness of cultural competence by exploring their personal perceptions and clinical experience of delivering culturally competent care through interviews. The study findings are a creation of an interactive process between the researcher and the student nurses which is associated with qualitative research methodology. Thus, a qualitative research method was chosen. Qualitative enquiry is necessarily underpinned by a reflective iterative process in which the study evolves and is shaped by the insights, knowledge and experience of engaging in the research process (Creswell, 1989), and this can include during data collection (Agee, 2009). In relation to this study, enquiries around student nurses' perception and clinical experience of cultural competence informed interview questions during the data collection process.

A qualitative method approach was utilised to understand UK student nurses' cultural competence preparedness through exploration of their perceptions and clinical experiences when delivering care to patients from diverse cultural backgrounds. This study intended to achieve three objectives outlined in chapter 3.2. Using a qualitative methodology helped understand the realities and experiences of this particular phenomena of nursing. Dickson-Swift et al. (2008) state that qualitative research helps researchers to understand, locate beliefs, values and emotions in the process of carrying out research. In qualitative research, researchers must attempt to understand the meanings and interpretations that people give to their behaviour in order to understand people's behaviour (Liamputtong, 2009). Essentially, this study was to understand the lived experiences of nursing culturally diverse patients and meanings student nurses give these experiences from their own interpretation. A qualitative approach, thus, allows for an exploratory, interpretative account that serves as contextual and explanatory function (Richie and Ormston, 2014).

While a study seeks to investigate subject areas that are deeply personal, related to values or beliefs or require insight into aspects of self, a qualitative approach allows for subtle and sensitive probing to get below the surface of a stylised or immediate response (Corti and Thompson, 2004). The complexity of the phenomena under investigation requires reflection by participants on both the nature of cultural competency and their own beliefs and views regarding cultural competence training in nursing. A qualitative design was, therefore, an appropriate method to be used as this would enable understanding of student nurses' preparedness of cultural competence through exploration of their personal perceptions and experiences of delivering culturally competent care in clinical practice.

3.3.1 Approach to qualitative research

There are many different strategies with different data sources and the different methods for exploring life, generating theory or describing the behaviour of a cultural group (Creswell, 1998). In order to choose an appropriate research methodology for this study the four major qualitative approaches were carefully considered. They are: ethnography, grounded theory, case study, and phenomenology.

Ethnography requires first-hand experience or continually observational methods for data collection (Creswell, 2014), whereas this study was looking for individuals' perception and understanding of their own experience without the researcher's participation. The researcher's presence or constant observation would potentially influence student nurses' thoughts, behaviour, and their true experiences of daily activity. As a result, the validity and credibility of the study findings could be affected. Therefore, ethnography does not seem to be a suitable methodology for this study. Grounded theory, arguably, could be potentially applicable to this study. However, its focus is on generating a theory from the research data, and data collection involves multiple stages with in-depth interviews (Charmaz, 2006), which is different from what this study was intended to do. This study's data was generated from having research questions and seeking to explain the meaning of what is happening from the participants. Additionally, the data collection was through semi-structured interviews from which participants were expected to explore their own world views. Thus, grounded theory is not the most applicable method to be used. In terms of case study methodology, the research is about collecting data in a particular context in which the researcher develops an in-depth analysis of the case; whereas this study was focusing on understanding participants' perceptions and experiences of cultural competence regardless of which context, and extracting themes from the data. Hence, case study is not appropriate.

Phenomenology is a design for the researcher to describe the lived experiences of individuals about a phenomenon as described by the participants (Creswell, 2014). This description culminates in the essence of the experiences for several individuals who have all experienced the phenomenon and typically involves conducting interviews (Giorgi, 2009). Since this study was to understand whether student nurses were fully prepared for delivering culturally competent care upon graduation through exploration of their experiences, Phenomenology seems to be the most suitable methodology to be chosen for this study.

The strength of phenomenology is that it seeks to understand, describe and interpret human behaviour and the meaning individuals make of their experiences (Dowling, 2007). Phenomenology focuses on creating detailed descriptions of specific experiences of a phenomenon (Carpenter and Suto, 2008). In relation to this study, since the data was collected through exploration of individuals' perceptions and

meanings of their experiences in the university and the hospital, the specific feature of phenomenology, which is the meaning of each participant's own experience of cultural competence in their practice, meets the need of this study. After careful consideration phenomenological approach is considered to be the most appropriate method for this proposed study.

3.3.2 Phenomenology

Phenomenology is not only a philosophy but also a research methodology. It is a method of enquiry expounded by the German philosopher Edmund Husserl (1859-1938), wishing to explore the 'lived experience' and gain understandings of participants' experiences. The focus of phenomenology discussion is often on Husserl's phenomenology grounding Colaizzi's phenomenological data analysis. Understanding the issues around phenomenology and phenomenological data analysis method is critical to the maintenance of rigor and value of qualitative research (Abalos, et al., 2016). Husserl's epistemological stance focuses on seeking to explain how to overcome the prejudices which stand in the way of pure consciousness, believing "consciousness was the condition of all experiences" (Moran, 2000, p.61). Husserl's descriptive phenomenology is the "direct exploration, analysis, and description of particular phenomena, as free as possible form unexamined presuppositions, aiming at maximum intuitive presentation" (Spiegelberg, 1975, p.57). He believed that researchers should "bracket" or stay away from the distraction of their own assumptions and preconceptions (Moran, 2000; Smith et al., 2009) in order to get to the essence of the subjective experience. This is not to eliminate the existence of that prior knowledge but to allow the bracketing of knowledge (Lauer, 1958). Bracketing is part of the process of Husserl's phenomenological reduction.

Phenomenology aims to provide insight into the experiences of individuals at particular event and searching for meanings (Moran, 2001). This usually requires one-to-one interviews which are transcribed and analysed to create meaning and understanding of individuals' experiences. Husserl advocates that the researchers suspend their own preconceptions and beliefs so as not to influence the findings. However, Husserl's pupil Heidegger (1889-1976) developed a broader attitude to

phenomenology which criticised Husserl's view. Heidegger felt the suspension of the researchers' beliefs was difficult but bringing researchers' understanding and experience to the research process is rather important. He concerned that "reduction of all objects to conscious phenomena seemed dangerously one-sided" (Colaizzi, 1973, p.2). He described the researcher as always worldly, being unable to meaningfully detach from the existing world of people, language and culture. Heidegger's approach to phenomenology is through a hermeneutic lens (Smith et al., 2012).

A French philosopher Sartre (1905-1980) extended the view of who we are and how we see the world (Smith et al., 2009). He supported and developed Heidegger's view on context, using our personal and social relationships to understand our experiences as being dependent on the presence and absence of our relationships to others. He emphasised the need to consider how people engage with the world and how these human encounters impact on the experience, rather than seeing a person in isolation. French phenomenologist Maurice Merleau-Ponty (1908-1960) developed phenomenology further by emphasising the interpretative nature of our knowledge about the world around us (Merleau-Ponty et al., 2004). He believed that whilst one can empathise with others ultimately one can never truly share another's experience as it belongs to their own position in the world (Merleau-Ponty, 1996).

In relation to this study, I am interested in understanding student nurses' preparedness of cultural competence through their own perception or interpretation of experiences of its practice in clinical settings. In order to gain that pure essence of student nurses' experiences of cultural training and delivering culturally competent care, I am conscious that I need to make sense through participants' own account of it by bracketing my own perceptions and prior knowledge about the phenomenon. Although I tried to set aside my own experience or conceptions as a senior nurse when interpreting student nurses' own experiences, I experienced difficulty of truly putting my own existing knowledge to one side and gain in-depth understandings of students' experiences of cultural competence purely from their words. As such, the findings are hoped to contribute to broader understandings of whether student nurses are fully prepared for delivering culturally competent care upon graduation. The systematic process of Colaizzi's (1978) seven steps data analysis strategy provided a useful guidance for this study in terms of its clear and structural process

for extraction of themes. For this reason, it was chosen as a data analysis framework for this study.

3.3.3 Colaizzi's phenomenological data analysis

Colaizzi (1978) developed a method to analyse phenomenological qualitative data. It is a method that "remains with human experience as it is experienced, one which tries to sustain contact with experience as it is given; and this can be achieved only by a phenomenological method of description." (Colaizzi, 1973, p.53). To attain this, the data needs to be thoroughly analysed. Colaizzi's strategy of descriptive phenomenological data analysis serves the purpose of this study, hence, was employed for interpreting the data collected.

Colazzi's 7-step analysis allows researchers to reveal emergent themes through a clear and logical structural process, thus, the fundamental structure of an experience can be explored. The process of Colaizzi's analysis provided assistance in extracting, organising, and analysing such narrative dataset; so, the key themes can be concluded in a logical manner. In addition, the accurate application of Colaizzi's process of descriptive phenomenology also helped to achieve the description of student nurses' living experience of delivering culturally competent care in clinical practice. It included understanding the data and identifying significant statements which in turn were converted into formulated meanings. Thereafter, groups of theme clusters were developed to establish the final thematic construct. Data analysis following Colaizzi's phenomenological approach was discussed in chapter 3.7 in details. Table 4 illustrates the process of descriptive phenomenological data analysis created by Colaizzi (1978).

Table 4: Colaizzi's data analysis process (1978)

Steps	Focus
1	Familiarising with transcripts
2	Identifying significant statements
3	Formulating meanings
4	Clustering themes
5	Developing main themes
6	Reduction of main themes
7	Return to participants if necessary

In using a phenomenological approach within this study, I was attempting to capture the lived experience of others whilst recognising that there would be an inevitable divergence between articulation of their experience and my personal construction and interpretation of that experience. As a nurse consultant I recognised that I had already experienced issues around cultural competency that I chose to explore, and the extent to which my own experience influenced the study must be acknowledged and monitored. The topic of interest has its origins in my own early experiences as a qualified nurse working with culturally diverse patients; knowing what I 'should' do, wanting to deliver the best quality care I could, but not necessarily feeling confident and capable in terms of 'how to do it'. In addition, having been supervising student nurses over the years provided me with some insights regarding how student nurses provided care to patients from diverse cultural backgrounds.

Lopez and Willis (2004) suggested that phenomenological researchers should have an in-depth understanding of the concept that is being studied, it is important in order to justify its inclusion or not in their study design. Moreover, it might be difficult to authentically listen to and reflect on the lived experience of participants if the researcher has not had personal knowledge and experience about the phenomenon of interest. My own cultural competence experience in the healthcare settings might help understand and interpret the meanings of participants' experiences. Reflexivity is an essential strategy that makes explicit views and judgments that affect the research process, including a full assessment of the influence of researcher's background, assumptions, perceptions, values, beliefs and interests (Carpenter and Suto, 2008). Hence, I have been mindful during the process of the study that it is crucial to integrate reflexivity into the research project.

3.4 Research sampling

The focus of qualitative research is about extensive understanding of individual's experience, thus, it is essential to recruit participants who can provide an in-depth amount of information of their experiences (Liamputtong, 2010). Determining the appropriate sample size for a qualitative study requires due consideration (Ritchie et al., 2014) as failure to recruit sufficient numbers into a study can impact upon data quality (Fusch and Ness, 2015). Morse (2007) suggests qualitative sampling has an

emphasis on meanings. In other words, the focus is on quality, rather than numbers, or quantity. While sufficient data must be generated in order to reach data saturation, that is, no new themes or concepts are emerging during analysis (Mason, 2010), given the complexity of most human phenomena, phenomenological studies usually benefit from a concentrated small number of cases (Smith et al., 2012). As such, ten pre-registered student nurses was the estimated number for this study dependent on when data saturation is achieved. Although data saturation, in reality, is difficult to identify, and there is little consensus in the literature, the key question to ask when making sampling decisions is whether the sample provides access to enough data and has the appropriate focus to enable research purpose to be thoroughly addressed (Mason, 2002). The important element in qualitative research is to select research participants meaningfully and strategically (Patton, 2002).

In relation to this study, a purposive sampling strategy was ideally appropriate and initially employed since it allows establishment of inclusion and exclusion criteria to ensure participants have the desired qualities or abilities. However, due to timelines of the study and difficulties of accessing student nurses in the local hospital at the time, I had to employ both purposive and snowballing sampling for this study. Details of the recruiting process are illustrated in chapter 4.5 Recruitment Strategy. According to UK Higher Education Statistics Agency (HESA, 2019), twenty percent (20%) students who were enrolled in an undergraduate course were international students between year 2017 and 2018. Those international students may become part of the future UK workforce upon graduation. Since this study was concerned with understanding student nurses' preparedness of cultural competence for delivering culturally competent care upon graduation in the UK society, recruiting students from diverse background is important in order to obtain in-depth information including each individual's interpretation and experience of cultural competence.

Randomly selecting students from the same cultural background might lead to insufficient data collection, consequently, data analysis and findings might be limited and unrepresentative. As a result, the validity and credibility of research findings would be compromised. For this reason, inclusion and exclusion criteria were set up prior to the recruitment process as table 5 illustrates. First year student nurses were excluded because they only had three months clinical placement according to the local university curriculum. Thus, they might not have sufficient theoretical

knowledge and clinical experiences to provide in-depth information about the focused research subject. Both second and third year students were comparatively more knowledgeable and experienced in cultural competence, hence, could be included in the study. However, at the time of recruitment only second year students were available in the hospital, as such, ten second year students were recruited. They were required to be able to communicate in English as language barriers between participants and researcher can lead to misunderstanding and misinterpretation of the transcript. It is also unrealistic to use an interpreter due to limited resources and high demands of workload in the hospital. More importantly, using interpreters potentially leads to a risk of misinterpretation of the meaning of the data collected, and some important information could be lost in translation. Inclusion criteria also included that participants needed to be interested in the cultural competence subject and willing to share their perceptions and experiences of delivering culturally competent care in their clinical practice. I would encourage them to freely express their thoughts, feelings and understandings of the research subject during the interviews, as a result, in-depth information could be obtained.

Table 5: Inclusion and exclusion criteria for the study

Inclusion criteria	Exclusion criteria
2nd or 3rd year student nurses	1st year student nurses
Good understanding and communication in English	English language barrier or poor proficiency to communicate in English
Interested in cultural competence in nursing context	Not interested in cultural competence in nursing
From the local University London	Not from local university students
Willing to share their clinical experience in culturally competent care delivery	Reluctant to share their culturally competent care delivery experience

3.5 Recruitment strategy

Participants who fulfilled the inclusion criteria were recruited from the hospital wards where student nurses were having their clinical placement. Both purposive sampling and snowballing methods were used for recruitment as previously explained. Ten female matured student nurses were recruited. They came from diverse cultural backgrounds (two from Nepal, one Jamaican, one Bambina Guinean, six British),

with different religions; and six of them had work experience prior to nursing training (see table 6).

Table 6: Participants/student nurses' information

Participants Pseudonym	Sex	Age	Nationality/Race	Religion	Work experience pre-nursing
Sofi	F	18	English/White	Christian	Nil
Julie	F	32	Nigerian/Black	Christian	Secretary
Carrie	F	19	English/White	Christian	Nil
Abigale	F	19	English/White	Christian	Nil
Salina	F	24	Nepal/Asian	Buddhist	Shop manager
Olean	F	20	English/White	Christian	Part time waitress
Smiri	F	22	Nepal/Asian	Buddhist	Nil
Charlotte	F	34	English/White	Christian	Healthcare Assistant (HCA)
Angela	F	29	Bambina Guinean/White	Christian	HCA
Sarah	F	26	Jamaican/Black	Christian	Self-employed business

There were some challenges I had to face during the process of recruitment. I firstly contacted the local university to find out the timeline of first year, second year and third year students' clinical placement. I then realised that only first year students were available in the hospital at the time of my recruitment. I attempted to access second or third year students in the campus but was advised not to because I was not permitted to interview students in campus as per University's regulation. I had no choice but waited until three months later when the second year students arrived. The university regulation and student nurses' clinical placement timetable, unfortunately, caused a delay to the study process. I then contacted hospital clinical tutor to find out students' rota as to which wards those second year students were allocated. I randomly found seven students on the wards and introduced myself and the study to them. Interestingly, six students showed great interest and were happy to participate, one was not so interested. Two of these six students then introduced other four students to participate because those four student nurse were from non-English culture backgrounds and very much interested in the research subject. Thus, ten second year student nurses were recruited as outlined at table 6.

While I aimed to mix male and female students for the sampling, I had to accept the fact that all ten participants were female due to limited timeline and difficult accessibility during the recruiting process. Although two male students were doing their clinical placement at the time of recruitment, they could not be recruited because they were first year students who had no clinical experience, and therefore, excluded from the study. While one could argue that the strong gendered element of the sample may impact the research findings, the sample for this study is considered to be valid as these ten student nurses were from different cultural backgrounds and had represented different views of cultural training and culturally competent care experience in their clinical practice. As such, they are able to provide rich information the study requires. Moreover, in reality, the predominant gender in nursing workforce is female nurses. Statistics showed only 11 percent (11%) of nurses in the UK were male by 2018 (Ford, 2019). Although more male nurses are needed to meet patient-centred care needs, readjusting the gender balance in nursing is still problematic around the UK and globally (Wish Report, 2018). Study (Dayer-Berenson, 2014) suggests that the value of the gender and whether one gender is considered more valuable than the other is clearly known within a culture. Therefore, the sample is believed to be valid for the research purposes. The gender issue is further discussed in the Study Limitation section in Chapter 6.2.

Participant information sheet and consent form were given and signed prior to interviews. Once participants confirmed their participation, I approached their ward managers and gained their agreement to release the student nurses from the wards for half an hour for the interviews. I then booked one of the meeting rooms and interviewed ten students individually within the next three days. Detailed ethical issues are discussed in chapter 3.8.

3.6 Data collection

Semi-structured interviews were employed as they are designed to ascertain subjective responses from persons regarding a particular situation or phenomenon they have experienced (McIntosh and Morse, 2015). Its purpose is to ascertain participants' perspectives regarding an experience pertaining to the research topic. Ritchie and Lewis (2005) suggest that during the interview, the interviewee typically

contributes more to the conversation, while the interviewer is actively engaged in listening and facilitating the flow of the conversation. The five components of Campinha-Bacote's cultural competence model provided guidance for the generation of interview questions. The answers to these questions help to gain insights into student nurses' cultural competence by critically examining their cultural awareness, knowledge, skill, encounter, and desire; enabled me to understand institutional and clinical factors that impacted on student nurses' cultural competence; and also promoted recommendations to improve cultural competence. Question 4 may look a less open question, however, if participants use "yes" or "no" as an answer, I am prepared to probe further by asking "why yes" or "why no", which will enable participants to explore their answers. Five key questions were asked to all ten participants (Appendix 3 outlines semi-structured interview questions):

1. What does 'cultural competence' mean to you? (This is to examine student nurses' cultural awareness and desire)

2. What was your cultural training like in your university and clinical areas? (This is to examine cultural knowledge and encounter)

3. What was your clinical experience like when you looked after a patient whose cultural background was different from yours or a patient from minority ethnicity? (This is to examine cultural awareness, skills, encounter, and desire)

4. Do you think you are fully equipped in your nursing training for delivering culturally competent care upon graduation? (This is to examine cultural knowledge, skill, and overall cultural competency by self-assessment)

5. What can be done to raise awareness, develop or improve cultural competence in your view?(This is to seek recommendations for further development of cultural competence)

One of the ward meeting rooms was used for the interviews as a comfortable and non-judgmental environment enables participants to explore rich information (Fontana and Prokos, 2007). Each interview took around half an hour. Ethical approval had been obtained from both the Hospital and the University Ethical Committee prior to the research project. The explanation of the study, the length of

interview time and scope of questions were explained (see appendix 1), and consent form (see appendix 2) signed before the interviews. Some soft drinks were prepared during the interview to show participants that their time and information was respected and appreciated. All interviews were audio recorded, and at end of each interview, I had summarised what the interviewee said and confirmed what I had interpreted was correct. All interviewees were asked the same key questions so data collected could be synthesised when analysing the data.

Interview questions (Appendix 3) were derived through an extensive literature review of cultural competency in nursing and constructed prior to the interview as this had helped to address what the study intended to find from the participants. Taylor (2005) and Kvale (2007) suggest that interviews may not go strictly the way that researchers prepared them. It is dependent on the answers from participants, and the researcher will probably need to ask additional questions based on progression of the interview. Open-ended questions were the dominant questions in this study, primarily because they allow researchers to follow participants' interests or knowledge (Johnson, 2002) and encourage the participants to express their perceptions and understandings in their own words (Taylor, 2005). In addition, I used simple English and spoke slowly at interviews to ensure research questions were easily understood as some of the student nurses' first language was not English and miscommunication could potentially occur otherwise. I spoke as little as possible to allow participants to talk about their lived experiences in their own terms (Low, 2007). For example, in this study, I asked 'What was your experience like where you looked after a patient whose cultural background is different from yours?' This allowed student nurses to explore their feelings and thoughts about their experiences, rather than asking a 'yes' or 'no' question, such as 'would you be competent or comfortable to look after a patient who is from an ethnic minority?' I also adopted some tactics including active listening throughout the interview and using non-verbal features such as eye contact to optimise engagement with participants.

Close observation of participants' facial expressions, pause and change of voice volume were carefully considered during the interview as they are equally important techniques. It is suggested that the interaction between participants and researcher is key to the data collection process in phenomenology and is influenced by how the

participant receives the researcher (Carpenter and Suto, 2008). In relation to this study, I was conscious that I was in a senior position as a nurse consultant to the student which could affect the information students provided as they might be slightly nervous. Hence, it was crucial to establish a genuine rapport and trusting relationship in the interviews. In order to create a more relaxed atmosphere for interviews, I also suggested the students to see me as a researcher only, and not to be affected by my job title. I paid much attention to the issues around insider researcher's position, which is discussed in chapter 3.8.2: Researcher's role. I had shown respect and commitment by involving the participants in all phases of the research. I used digital audio recorder for recording the interviews. Although a digital audio recorder was highly desirable equipment to use throughout the interview without interruption, some non-verbal features could not be recorded but could have significant impact on the conversation. Therefore, I frequently made notes on paper during the interviews including noting down pauses, facial expressions, tones, and gestures, etc. Those notes were important reminders for later when I transcribed the interview conversations.

I had personally transcribed the interviews although it was very challenging and time consuming. Kvale (2007) recommends that the researcher or interviewer should transcribe their own interviews, as they would learn much from their interview and have already started analysis of the meaning of what was said. The strength for me as the researcher to transcribe the interviews is that it helped me code the data and organise illustrative examples of code pieces. When I listened to the audio recordings, I could hear underlying tones which reminded me not only what interviewees said but also how they said it. The transcribing process undoubtedly helped me to accurately analyse the data and make sense the meanings of what participants were saying. According to Daly (2007), an hour interview may take up to experienced transcribers up to six hours to transcribe. I had interviewed ten participants; it took me over six hours to transcribe each interview. As a Nurse Consultant who works in very busy medical department, spending this amount of time for a research project was very challenging. In order to avoid distractions form work, I had to take annual leave to transcribe the interviews.

3.7 Data analysis procedures

The phenomenological approach was guided by Colaizzi's (1978) seven stages analytical framework. The essence of phenomenology was taken into consideration which suggests interpretative theory and understanding the relationship between 'the part and the whole' throughout the process of data analysis. Whilst Colaizzi's framework provided analytical guidance, a method for identifying, analysing and interpreting patterns of meaning was needed, such as thematic analysis (Clarke and Braun, 2014). Thematic analysis offers a great flexibility for qualitative researchers; it can be applied across a range of theoretical frameworks and research paradigm as a tool or technique (Holmqvist and Frisen, 2012). In relation to this study, the phenomenological question of culture and competence guiding the enquiry was a key, but to support final recommendations and offer a more practical application of theory to practice, thematic analysis could support a structured response through thematic content going forward. As such, thematic analysis method was adopted to analyse the data alongside Colaizzi's framework. Thematic analysis was used to facilitate in-depth explorations of participants' perceptions and experiences of cultural competence as it helped to analyse transcription in an orderly fashion and derive themes from the data collected.

The process of Colaizzi's (1978) strategy of descriptive phenomenological data analysis was used to provide assistance in extracting, organising, and analysing the data. His strategy enabled the study to achieve the description of living experience of student nurses' cultural competence preparedness and delivering culturally competent care in their clinical practice. It included understanding the data and identified significant statements which in turn were converted into formulated meanings. The clusters of themes were then developed to establish the final thematic construct. The benefit for using thematic analysis alongside Colaizzi's framework was that thematic analysis provided accessible and systematic procedures for generating codes and themes from the data. Braun and Clarke, (2013) suggest that the emphasis of thematic analysis is on rigorous and high quality data analysis by identifying and interpreting, not necessarily all, but key features of the data content. Not only was it useful as a toolkit for robust coding, clustering, and formulating themes, it was particularly helpful to capture patterns within data in relation to participants' lived experience, views and perspectives, and behaviour and

practices. Braun and Clarke (2013) also suggest that thematic analysis is easy to use for researchers who are seeking to understand what participants think, feel and do but less qualitatively experienced. As a novice researcher, I conducted this study to understand student nurses' institutional and clinical experience of cultural competence via their feelings, thoughts and perspectives. Thus, thematic analysis was an appropriate tool to be used alongside Colaizzi's phenomenological framework for identifying these specific features of the data. Guided by Colaizzi' framework, I have divided the analytical process into seven stages. The details of analytical process based on data collected through semi-structured interviews are illustrated in Appendix 4.

- **Stage 1**: Acquiring a sense of each transcript. That is, the interview transcripts were reviewed several times in order to understand the fullness of the experience of cultural competence as described by each student nurse.

- **Stage 2**: Extracting significant statements. In this stage, the important fragments were highlighted in the transcripts that identified or informed my understanding of participants' experiences of delivering culturally competent care. Each transcription was analysed after each interview, significant statements and narratives were highlighted. Pseudonyms, page and line numbers were used. The transcription paper was filed and kept in a locked cabinet.

- **Stage 3**: Formulation of meanings. In this step, I constantly referred to original transcriptions of the interviews since I needed to find out what they meant from what they said. Colaizzi (1978) explained in finding these formulated meanings, the researcher must illuminate the hidden meanings from what the participants said; and must not "formulate meanings which have no connection with the data" (Colaizzi, 1978, p.59). My interpretation of the meaning of significant statements was written down as memos. It was necessary to repeatedly reflect on my own assumptions to the participants' narratives and make relevance with related literatures. In this stage, the data had been coded and categorised.

- **Stage 4**: organising formulated meanings into clusters of themes. In this stage, peer review of the clusters of themes was done to ensure the interpretive process was clear and accurately described. The experienced researcher was invited to listen to the audio recorder and assess the emerging information from the clusters of the themes and then consolidated to form the main themes.

- **Stage 5**: Describing the investigated phenomenon. The main themes were described in detail. The data was discussed with other experienced phenomenology researchers in the hospital to ensure that there was no difference in interpretive decisions.

- **Stage 6**: Describing the fundamental structure of the phenomenon. The theme descriptions were further reduced to a statement of their essential structure.

- **Stage 7**: Returning to the participants. The final validation of the data analysis needs to involve returning to the participants for another interview to ensure that they could recognise the themes and final statement. This is what Colaizzi called member checking. However, Liamputtong (2010) argues that in reality, it is not feasible to conduct the process of member checking in some studies. Since I had summarised what the student nurses said at each end of the interviews to confirm if I had interpreted their views correctly, all student nurses were happy with my interpretations based on their descriptions. I, therefore, did not believe it was necessary to return to the participants for further interviews.

3.8 Ethical issues

The ethical issues that needed to be considered were extensive, and they were reflected through the research process. These issues applied to all stages of the research, which were explicitly illustrated as following three elements: confidentiality and data protection, the role of researcher, and sensitive issues.

3.8.1 Confidentiality and data protection

Despite the fact that rigor of the research methodology needs to be carefully assessed which will be illustrated in the data analysis section (Chapter 4.7); the relationship between researcher and participants in qualitative research is complex (Guillemin and Gilliam, 2004). Even the use or avoidance of certain words when guiding participants in the protocol can sometimes have substantial effects on the research outcomes. As such, I had considered the words and phrases used in the invitation letter (Appendix 1) and consent form (Appendix 2) carefully before conducting the interviews. Cowburn (2005) suggested that privacy and confidentiality issues need to be identified as reasons for its particular importance in interview research. Thus, detailed information of privacy and confidentiality issues were given to the participants and informed consent obtained prior to the interviews. Participants were assured that their anonymity of names, roles, and information they provided at the interview would be protected. Pseudonyms were used in the study. Research participant's information sheet (see appendix 1) was provided. Full explanation of the research, length of interview time needed and scope of research questions were informed. Participants' agreement to commit to the research and their consents were obtained (see appendix 2 for participant consent form) prior to the interviews. Participants' anonymity and confidentiality had been protected throughout the research process.

For the accuracy of contents of the interviews, a tape recorder was used throughout the course of the interviews after consent forms were being signed. Written notes were also used to record key information participants described as reminders for later transcription. Audio and written data was stored in a locked cabinet in a locked office, with authorised access by the researcher only based on the Data Protection Act (2018).

3.8.2 Researcher's role

Researchers need to protect their research participants; develop a trust with them; promote the integrity of research; guard against misconduct and impropriety that might reflect on their organisations or institutions; and cope with new, challenging problems (Israel and Hay, 2006). Since this study employed descriptive

phenomenology as a method of research, I, as researcher, was required to set aside (which Husserl called “bracket”) the assumptions, beliefs, and bias about the phenomena, so the pure phenomena is isolated from what is already known about a particular phenomenon (Speziale and Carpenter, 2007). Bracketing is done to avoid researcher’s biases and preconceptions to interfere with the object of the study by constantly assessing it (Lopez and Willis, 2004). While it was difficult to completely set the researcher’s pre-knowledge and experience aside, I was consciously reminding myself to listen and interpret the participants’ view as what they said throughout the process of interview and transcription.

I was conscious that my dual roles of being a nurse consultant in the hospital and an insider researcher might potentially have significant impact on student nurses involved with the study. On the one hand, with my knowledge of the present situation, I could develop valid research questions and rapport with participants based on my rich understanding of the issues needing investigation; on the other hand, my perspectives and senior position could potentially influence the participants’ view during the process of data collection and analysis. To maintain study’s validity, credibility and trustworthiness, I had been mindful to minimise or “bracket” personal values and experiences that influenced the participants throughout the study. Furthermore, as an insider researcher, I was conscious about the risk of being in a role of formal or informal power, I, therefore, constantly reminded myself to play a researcher’s role rather than a nurse consultant so participants did not fear of being judged when sharing their information during the interview.

Although insider researcher’s position and power are often criticized, bias can be minimised. It suggests that how the researcher interacts with participants can impact on the validity of the findings (Smith and Noble, 2014). Therefore, during the process of interviews, I spoke as little as possible to avoid bias of my personal view of the subject and allow participants to express freely their own views. In order to grasp the essential lived experience of cultural competence from the student nurses, I had attempted to shed my prior knowledge related to cultural competence in nursing education and practice. However, it was very difficult to completely detach my own worldview from the research subject and easy to be drawn into my own nursing experience during the conversation which might lead to a subjective interpretation of

the meanings of participants' experiences. As what Heidegger (1962) argues that it is difficult to suspend the researcher's view but bringing the researcher's understanding and experience to the research process is rather important. Although my professional experience in delivering culturally competent care had helped to understand the student nurses' views, I was conscious and constantly assessing my position as a researcher to avoid unintentional bias, making sure "bracketing" when possible. At the end of the each interview, I had summarised what the participant said to verify what I understood was what they meant. Nonetheless, one can argue that bias may still exist no matter how hard the researcher tries to minimise.

As English is as second language for me and some of the participants, I always communicated in clear, straightforward, appropriate English to avoid any misunderstandings. Many papers (Richards and Schwartz, 2002; Ensign, 2003; Cowburn, 2005) suggest that researchers can be harmed too due to emotional distress during the interviews, especially as a sole researcher. To avoid being emotionally distressed, I had to follow the Trust's lone-worker policy and gain formal and informal network support such as peers and supervisors as recommended. During the process of transcribing, I ensured constant comparisons across participants' account, looking through participants' respondent validation, and persistently referring back to my written notes including non-verbal expressions and body language to reduce analysis bias. Additionally, the verified summary of each participant's description had minimised bias so that validity of research findings was maintained.

In addition, trustworthiness, dependability, conformability, and authenticity of this study were measured to fit Goodness Criteria (Marshall, 1989) for qualitative research, and the rigor was well presented throughout the research. It is generally accepted that without rigor, research, whatever the methodological approach, fails to contribute to the professional knowledge base (Kvale, 2007), and therefore, is not applicable to the practice. While some researchers (Carpenter and Suto, 2008, Tobin and Begley, 2004, Angen, 2000; Raines, 2008) believe that validity and reliability are incompatible in qualitative research because they are "being too subjective" (Angen, 2000, p.379). Johnson and Waterfield (2004) argued that qualitative research holds the view that reality is socially constructed by an individual, and while this socially constructed reality cannot be measured, it can be interpreted, understanding of

qualitative research cannot be separated from context. Hence, qualitative data cannot be tested for validity using the same rules and standards, which are based on assumptions of objective reality. Since participants were student nurses, I had obtained approval from not only from the Hospital, but also University Ethics Committees to ensure all ethical issues were carefully considered prior to the study.

3.8.3 Sensitive and environmental issues

This study involved a few sensitive issues including different races, cultures, thoughts and experiences. Some of the experiences might not be pleasant to the participants and could potentially make interviews emotionally intense. Hence, I had to ensure participants understood the aim of the research, their right to withdraw, and pause or switch to therapeutic conversation if they became too upset or emotional. Non-verbal communication was used too such as eye contact, nodding, etc. to show my understanding, respect and appreciation. The interviews were conducted in a ward meeting room to ensure a comfortable environment and not being disturbed during the length of the interviews. Since student nurses were not counted as staffing numbers in the wards, it was negotiable to conduct the interview when they were on duty. This way, I had shown the participants that their time and participation were respected and appreciated.

3.9 Reflexivity

Reflexivity is an awareness of the researcher's role in the practice of research and the way this is influenced by the object of the research, enabling the researcher to acknowledge the way in which he or she affects the research process and outcomes (Alvesson, et. al, 2008). Haynes (2020) suggests reflexivity goes beyond simple reflection which includes considering the complex relationship between production of knowledge (epistemology), the process of knowledge production (methodology), and the impact of the researcher (ontology).

Reflexivity within the context of nursing research can be seen as "the process of a continual internal dialogue and critical self-evaluation of the researcher's positionality as well as active acknowledgement and explicit recognition that this position may

affect the research process and outcome" (Berger, 2013, p3). In other words, reflexivity involves thinking about how researcher's thinking came to be, how pre-existing understanding is constantly revised in the light of new understanding, and how this in turn affects the research (Haynes, 2020). In relation to this research, reflexivity had been integrated throughout the research process including theoretical, methodological and analytical processes. I used filed notes, a reflective journal, and supervision to support a reflexive approach, engaging with my ontological position and choice of research process. I firstly articulated my motivation of the research, theoretical and personal; as they shaped the way the research was received, carried out and produced. Secondly, during the process of methodological reflexivity, I carefully considered the effectiveness of data collection and analysis process; particularly with ethical issues and power relations to the participants, as these issues would influence the research findings. In addition, I consciously bracketed my pre-existing knowledge and experience of the research subject to minimise bias and influence on the participants' understandings. Finally, I transcribed the data as objectively as possible to ensure the new understanding of the research subject was transformed through the words of the participants. Thus, the validity and credibility of the research were maintained.

4.0 Summary

This chapter critically analysed appropriate research design and a rigorous research methodology used; explicitly demonstrated the quality and credibility of the data collection, and data analysis process. Phenomenology was carefully chosen as the research methodology and Colaizzi's strategy of data analysis was used for the formation of themes. As a result, the research findings in the next chapter are deemed to be valid and credible. It is worth pointing out that any research design is experimental and not all experiments go to the plan. I had to face some challenges during the process of recruiting participants. The main barrier was from the university where accessing students was not permitted as a non-faculty staff. Although I eventually overcome the difficulties, the challenges had caused some delay in the process of carrying out the study.

Ethical issues were carefully considered throughout the process of planning, recruiting participants, data collection, analysis, and transcribing. Critical reflections throughout the process of the study had helped, particularly, with the completion of data collection and analysis. Reflexivity helped to question the process of research, in terms of how the methodological conduct and pre-existing knowledge transformed and influenced new knowledge. In addition, reflexive methodology enabled explicit illustration of ontology and epistemology of the research. The robust procedures adhered to in the main study and consideration of ethical issues intended to maintain the credibility, trustworthiness, and applicability of the study. Consequently, the study findings are hoped to be trustworthy and reliable. The study findings in the next chapter will be transformed into practice and used as evidence to support the development of cultural competence among student nurses.

Chapter 4: Research Findings and Discussions

4.1 Introduction

This chapter outlines the findings from the data collected via ten semi-structured interviews. Sub-headings are used to ensure an in-depth data analysis and comprehensive discussions throughout this chapter. Campinha-Bacote's model of cultural competence provided the theoretical underpinning for the discussion and implications of developing cultural competence among student nurses. There were four main themes developed from the data analysis: 1. student nurses' cultural competence level; 2. lack of formal cultural competence training in nursing; 3. clinical factors impacted on student nurses' cultural competence; and 4. student nurses' recommendations for cultural competence. These study findings are explicitly discussed in relation to the existing literature to identify how this study illuminated and challenged the findings of other studies. This chapter also explains how these findings relate to the research aims and objectives. The findings will be used as evidence to support the development of cultural competence among student nurses locally.

4.2 Research findings

The study produced four key findings from the data analysis:

- Student nurses' cultural competence level: good cultural awareness, skills, desire, and encounters but limited cultural knowledge. Overseas student nurses and those who had pre-nursing work experiences were more adaptive and confident to learn and develop cultural competence at personal level.
- No formal cultural competence training in nursing curricula, which may have possible likelihood link to insufficient cultural knowledge among student nurses.
- Four clinical factors impacted on student nurses' cultural competence including shortage of staff; language barriers and lack of interpreters; poor learning environment; and no cultural assessment in the nursing care plan.

- Student nurses' recommendations for cultural competence were to encourage working in partnership at multiple levels including university, clinical settings, policymakers, as well as individuals. HEIs and healthcare settings are equally responsible for the support needed to enable student nurses achieve cultural competence upon graduation.

4.2.1 Theme 1. Level of cultural competence

The aim of the study was to critically examine student nurses' preparedness in their nursing training for delivering culturally competent care upon graduation. The five components of Campinha-Bacote's theory of cultural competence including cultural awareness, knowledge, skill, encounter, and desire provided framework for this study. All five components were explored through student nurses' own perceptions in terms of how competent they evaluated themselves for each component. This study involved ten student nurses (see table 6 for participants' information) who were mixed cultural backgrounds including five local students and five overseas students (5 English, 1 Nigerian; 2 Nepalese; 1 Jamaican; 1 Bambina Guinean). Obviously, student nurses from diverse cultural background had different worldviews of the same experience, as such; the information provided would enhance the validity and credibility of the study.

The study suggested that all participants (N=10) were motivated to learn and to know different cultures, and eight (N=8) of them defined cultural competence as '*having cultural knowledge and awareness; possessing cultural skills such as understanding diverse beliefs, values, and being able to adapt to that particular culture*.' According to students' self-evaluation, all (N=10) of the participants perceived themselves as fairly good with four elements of cultural competence including cultural awareness, skill, encounter, and desire; but cultural knowledge was somewhat lacking. The assessment of each component of cultural competence was illustrated in below sections.

a. Cultural awareness

Cultural awareness is an essential part of the cultural competence process where the nurse self-examines his or her own culture and beliefs which allows him or her to

be more aware of the cultural needs of others. Campinha-Bacote (2007) suggests this process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different. Without recognition of the influence of one's own cultural or professional values, there is risk of imposing one's own values and patterns of behaviour on another culture. This study finding showed that eighty out of ten (N=8) participants were confident with awareness of cultural difference and conscious with their own patterns of behaviour when nursing patients from different cultures. This finding echoed other studies' result, such as Govere et al. (2016), which showed fairly good cultural competence among nurses through self-report analysis. Nonetheless, participants were not so confident with in-depth cultural knowledge and how to appropriately handle different cultural situations. For example,

I intended to examine participants' awareness of different culture and reaction from it in clinical settings, hence, asked: "*What was your clinical experience like when you looked after a patient whose cultural background was different from yours?"*

> Olean said: "*I am aware of different cultures but not confident with every culture."* Olean said this in an open and honest manner and, especially when she said "not confident with every culture", she lowered her head and indicated as though she was embarrassed. The way she was describing her experience gave me the impression that she was good at recognising different cultures but lacked confidence to react to every culture that is different from hers.
>
> Abigale said: *"I am aware of what I am saying when I speak to the same culture people, but when I speak to people from different cultures I cannot speak light-heartedly."* Abigale felt confident to culture difference and was aware how to react in a sensitive manner toward culturally diverse patients.
>
> Angela is originally from Bambina Guinea and appreciates the importance of empathy as a nurse. She said: "I am culturally different from here. I had to be adaptive to everything when I first came here. Nurses should be non-judgemental because we are all different, different religions, different beliefs, etc. I feel really bad when I see nurses undermine those who don't speak English. We can use body language to communicate, or try to understand

them." Empathy and being non-judgemental are the core values throughout Angela's experience when looking after patients from different culture.

Eight (N=8) participants expressed confidently that they were aware and sensitive to different cultures. They highly recommended that adaptive behaviour was a must to establish professional nurse-patient relationships, which could help nurses to meet individual care needs. The nurse-patient relationship has been considered as a central part of cultural competence care. Without good nurse-patient relationships, care cannot be effectively delivered. Communication skills and behaviour play important roles in nurse-patient relationship especially communicating in a culturally competent way require sensitivity to both verbal and non-verbal communication cues (Krauskopf, 2008). This statement was echoed by three participants' (Julie, Sarah, Smiri) views in this study which was using verbal and non-verbal communication skills to help establish a good nurse-patient relationship. For example, Julie encountered a patient who could not speak English. She used IPAD as a tool for translation which had helped to establish a trustworthy relationship between them. Transcultural theory pioneer Leininger (2002) specifically emphasised that care and caring were an impetus to cultural competence and this was an action where the nurse took into account individual differences (the beliefs, values and modes of care). The action that the nurse takes in response to a culture can be seen as the interaction with the particular patient, within the context of care delivery.

Communication highlighted in this study has been advocated as the most important skill in cultural competence in literature, which is consistent with professional nursing practice requirement in the UK (NMC, 2014; 2015). Effective communication between nurses and patients improves patient satisfaction with healthcare (Change et al., 2013). In addition, actual engagement not only with the patient but also families and communities helps to stimulate knowledge, data collection, and learning, therefore increasing awareness, which leads to cultural competency (Kirkpatrick and Brown, 1999). Essentially, nurse-patient relationships are about cultural skills required in order to deliver culturally competent care for patients from diverse cultures.

When I asked: "*what does cultural competence mean to you*?"

All (N=10) participants believed that '*respect, understanding, appreciation of different cultures, and treating patients individually'* were important to enable them to deliver culturally competent care. Answers include:

> Sofi answered: "*understand patients from other cultures and what you can do to care about them".*
>
> Julie answered: "*you want to learn other cultures, respect and share what you know to be able to provide appropriate care..."*
>
> Abigale answered: "*understanding, awareness and adaptation of different cultures…" "We should know who they are individually and the role of nurses to them".*
>
> Salina answered: *"having the knowledge of what is appropriate, what is not. Remind yourself that not everyone is the same..."*
>
> Olean answered: *"ability of knowledge, ability to adapt cultural difference. Accept the way it is with different cultures..."*
>
> Simiri answered: *"every patient is different. Their views, beliefs, values should be respected. Understanding their cultures is important..."*

All participants expressed their understanding of definition of cultural competence with confidence. Those elements of culturally competent behaviour addressed by student nurses including understanding, respect, appreciation and adaptation of different cultures have also been revealed in many literatures (Campinha-Bacote, 2007; Anderson 2001; Bhugra et al., 2011; Bhui et al., 2007). The authors recommended that cultural competency was about skills that clinicians could employ to understand the cultural values, attitudes and behaviour of patients, especially those cultural backgrounds that differed from that of healthcare professionals. Having the skills to deliver culturally appropriate healthcare and instructions to culturally diverse patients can be challenging for nurses, who sometimes have difficulty communicating without the use of medical terminologies. One can argue that effective communication requires not only knowledge but also skills and tactics which student nurses may need to learn throughout their nursing training. Skills and

tactics can be used appropriately at different situations with different encounters, as culture is socially constructed and evolving.

One participant Charlotte stressed that nurses should see each patient as an individual because she believed that "*even if they are from the same culture, they may be different…"* The same view has been suggested in Brannigan's (2008) study that even within the same culture there were likely to be variations in attitudes, knowledge, and behaviours on the one hand, and religious values and linguistic variations on the other. It is worth highlighting that people's behaviours, attitudes, knowledge and religious beliefs are classified as secondary characteristics of culture, according to Purnell (2013); and the secondary characteristics are influenced by people's life experiences and different circumstances, can and often do change over time. Campinha-Bacote's study (2007) revealed similar findings around understanding the concept of culture and gaining knowledge and skills about diverse cultures. Knowing that culture is socially constructed in nature, one requires highly sensitive cultural awareness to be able to provide appropriate care for the individual patient under specific circumstances. Practically, for students, further support could be provided by integrating assessment of cultural needs into nursing care plan. Thus, cultural assessment data can be analysed and culturally competent care achieved. Participants' answers to the two research questions suggested that student nurses' cultural awareness were good. They also pointed out that nurse-patient relationship played central role in delivering culturally competent care, and effective communication was the key to enable professional nurse-patient relationship.

b. Cultural skill

Cultural skill in the context of nursing is defined as the ability to collect relevant cultural data of the patient as well as accurately performing culturally based assessments (Campinha-Bacote, 2007). Cultural assessment involves collecting information of individual patient's cultural belief and values to determine their care needs and intervention required; and also physical examinations to know each patient's physical, biological, and physiological variations. Examples include differences in body structure, skin colour, and laboratory variances (Leininger, 1978). In this study, two participants (Charlotte and Sarah) highlighted that cultural

assessment was not included in current nursing assessment in the hospital where they had their placement, which had a negative impact on individualised care for patients. Sarah stated that even if there was an element of cultural information in patients' medical notes which was often seen as unimportant information. She said with frustration by frowning and slightly raised voice:

> "*In the Acute Medical Unit (AMU), the nursing staffs lack cultural awareness. Actually some patients have 'patient passports' where there is minimal cultural information in it such as religion, nationality, etc. but no one is interested in reading it..."*

Sarah's statement highlighted a concerning issue of how nursing assessment was carried out in UK hospitals. Whereas in the USA, cultural assessment was incorporated into patient's admission care planning process long time ago because cultural information is considered as an essential element to the design, implementation, and evaluation of individual's healthcare. Similarly, Participant Charlotte also expressed the importance of conducting individual patient's cultural assessment because variations in thoughts and behaviours exist even within the same culture. She said "*even if they are from the same culture, they may be different…"* Charlotte and Sarah's concerns raised a clinical nursing practice issue in the UK which was whether patient's cultural assessment should be included in the nursing care plan and formally documented in patient's history record. If cultural background influences people's thoughts, beliefs, values, behaviours and so on, then, it needs to be classified as an essential piece of information to be carefully assessed when making a care plan for the individual patient. This finding could potentially provide evidence for the change of future nursing practice, which is further discussed in Chapter 5.4 Recommendations of the study. Participants' other essential skills such as communication and establishing nurse-patient relationship were fairly good as already revealed in cultural awareness section.

c. Cultural encounter

Cultural encounter is the process that encourages nurses to directly engage in cross-cultural interactions with patients from diverse backgrounds. Direct interactions helps to refine or modify one's existing beliefs and values about a cultural group hence, prevent possible stereotyping that may have occurred.

Cultural encounter also involves an assessment of the patient's linguistic needs. Using formally trained interpreters may be necessary to facilitate communication during the process of care delivery. Language barriers between nurses and patients can lead to misunderstandings and unsatisfactory clinical outcomes.

In this study, all (N=10) participants were enthused with directly interacting with culturally diverse patients, however, four (N=4) participants (Julie, Charlotte, Salina, Angela) expressed language barriers they came across had negatively impacted on culturally competent care delivery. Angela was particularly frustrated with the fact that no professional interpreter could be accessed in the hospital where she had her placement. Angela said with somewhat disappointment:

> "*In an ideal world, I wish I could pick up the phone and ring interpreter just like how we access porter service";* and "*communication has to be the priority for patient care, if you can't understand what they want, how can you provide care? And also, the patient has right to know what is going on, what we are doing and why."* Angela felt quite upset about being unable to provide good care due to resources deficit. She had HCA experience prior to nursing training, and was relatively experienced about culture diversity. She believed nurses should be passionate about caring patients irrespective of their diverse cultural backgrounds.

It was recognised that communication difficulties were a barrier and a challenge when there was no shared language proficiency between nurse and patient (FRA, 2013; Hart and Mareno, 2014). Hence, a translation service or an interpreter is considered as a more effective way of communicating. Ideally, hospital and community settings should have easy access to professional interpreter services, just like what Angela indicated in the study that things should be properly done "*in an ideal world*". However, unsatisfactory situations such as no interpreter service might always exit, very often we have to overcome the challenges we face in a real world. We might have to think and do things in a creative way. For instance, family members often could be invited for translation unless it was consent for surgery or invasive procedures' that needed to be signed by the patient himself or herself. Involving patients' relatives for an effective communication could also improve nurse-patient relationship, and subsequently, meet individual patient's care needs.

Whilst communicating in the same language is import, Schouler-Ocak et al. (2015) suggest that cultural competency is not only about learning the language of patients but also about respecting cultural differences and making sure their beliefs, values and religions are appreciated in order to meet their healthcare needs. Recognising the fact that lack of interpreter service often happens in the health care settings, student nurse may need to interact with patients who have language barrier in a creative way. Involving family and careers for planning nursing care and clinical management seemed to be an effective way to improve culturally competent care.

d. Cultural desire

Cultural desire is the motivation of nurses who want to, rather than have to, engage in the process of becoming culturally competent (Campinha-Bacote, 2007). Care and compassion have been highlighted in Campinha-Bacote's cultural desire process. It suggests that cultural desire includes a genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants.

In this study, all participants (N=10) showed genuine interests in learning and respecting different cultures, and being adaptive to different cultures. Examples such as:

> Sofi's statement: "*we should respect patients' choice, we can't force them…"; "we have great appreciation on what other cultures are and what they do..."* She demonstrated her cultural desire as to "*understand patients from other cultures" and know "what you can do to care about them".* Sofi has showed her keenness to learn different cultures and adapted herself to that culture in order to provide specific care to that particular patient. As a listener, I could sense her strong desire to learn and to adapt to diverse cultures.

Sofi also described her experience of nursing a female patient from Africa who had her own schedule for meals which was different from hospital timescale. She appeared to be "stubborn" and unpopular to other nurses on the ward. Sofi talked to her and understood she had a gastrectomy which changed her normal meal time, and she had to eat four to five times per day in order to keep her stomach

comfortable. Sofi empathised her experience and made all other nurses aware of her medical history. Since then, all nurses respected her choice of meal time and the patient was much happier. I was touched by the difference Sofi made to the patient. It was a perfect example of good cultural awareness, skills, encounter and desire.

> Julie's statement: *"we should be open-minded and friendly..; "I am Nigerian. I am interested in other cultures and respect other cultures, keen to learn other cultures."* Julie said with enthusiasm and compassion.
>
> Sarah's strongly believed that *"standardised care is not appropriate for everyone. We should be able to provide person-centred care to that specific patient."*
>
> Charlotte also stated: "*it is important not to forget care and compassion as a nurse..."* To Charlotte, the essence of nursing is about care and compassion, which has driven her to learn about different cultures in order to deliver good care to the diverse population.

Sarah's statement echoed what Campinha-Bacote (2009, p.183) said "people do not care how much you know until they first know how much you care". Abigale showed her cultural desire as: "*Understanding, awareness and adaptation of different cultures; knowing who they are individually and the role of nurses to them".*

All participants' enthusiasm and willingness to learn and become culturally competent were truly inspirational. Some participants' clinical experiences of looking after culturally diverse patients were touching. I could almost see their professionalism as future qualified nurses when they were exploring their experiences in the hospital.

e. Cultural knowledge

Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups (Campinha-Bacote, 2007). Obtaining cultural knowledge requires HEI to design and implement appropriate cultural training to prepare student nurses become culturally competent upon completion of nursing training. Although the exploration of participants' experiences and perception of cultural competence demonstrated that student nurses had

achieved a good level of cultural awareness, skills, encounters and desires; their educational foundation of cultural knowledge was lacking and overall cultural competency could be improved. All (N=10) participants denied knowledge of cultural competence theory and claimed that no formal cultural competence training in their nursing curricula. When I asked:

> *"Let's talk about cross-cultural nursing theories and theorists? Have you heard of Leininger or Campinha-Bacote as cross-cultural theorists?"*

Unexpectedly, all (N=10) participants gave negative answers. In other words, none of the student nurses knew or heard of cross-cultural nursing theories or theorists. It is interestingly that despite the fact that participants did not know the theory or theorists, they had presented with a good level of the other four elements of cultural competence including cultural awareness, skills, desire and encounters. The exploration of student nurses' experiences of cultural competence also showed their professional nurse-patient relationships were fairly well established and maintained, and care was delivered reasonably well during their clinical placement. One question raised in my mind at this point was that, the phenomenon of inadequate cultural knowledge among student nurses might be associated with insufficient foundation of nursing education. I was wondering if cultural competence training was formally integrated into nursing curriculum, those students might be more confident to answer the above questions and their cultural competence could be further enhanced. With this query in my mind, I then asked the next question:

> *"What is your cultural training like in your university and clinical areas?"*

4.2.2 Theme 2. Inadequate cultural training in local university

In response to above question, all participants (N=10) confirmed that there was no formal cultural competence training in their nursing curricula. Seven (N=7) participants were strongly concerned about inadequate cultural training in their university. They believed that the university should be responsible to support them to gain cultural knowledge by integrating cultural training into nursing curricula. Whereas the remaining three (N=3) participants were content and believed that there

were many overseas students in the university from whom they could learn about different cultures.

When I asked:

> *"What is cultural training like in your university and clinical placement areas? Or can you comment about cultural training throughout your nursing training?"*

Sarah suggested that cultural knowledge could be learnt at a personal level. She stated:

> "*We need to be self-taught for cultural knowledge and awareness".*

Sarah described cultural awareness is not something that can be easily taught in university but can be self-learnt as students come across people from diverse cultural backgrounds every day. To some extent, I understood what she meant and agreed that cultural awareness is related to personal experience, desire and encounters, the more one is exposed to diverse cultures the more he or she becomes adaptive and competent. I reflected on my own personal and professional experience over the years, those countless people I encountered made me more confident and competent for dealing with cultural diversity matters. I supported Sarah's view that it was helpful to learn cultural knowledge at a personal level, but it was more interesting to find out if all students believed learning at a personal level was sufficient for cultural competence.

In contrast, Sofi answered with great concerns as her facial expression appeared to be frustrated and her voice was slightly raised:

> "*not sufficient cultural training, no one tells you about how to nurse patients from different cultures when it comes to health care environment, you have to find out yourself..."; "some modules mentioned about odd things but not in details..."; "when you see people around you from different cultures do things differently, you go 'wow' and realised you have to adapt.".*

Sofi expressed huge “disappointment” towards “cultural training” in the university. Her voice was filled with frustration when she said that the university did not meet her learning needs, and it was a surprise to her sometimes when she realised that different behaviours are resulted from cultural difference.

> Julie answered: “*not a lot. University hasn’t got into culture yet. I think I learnt more in clinical practice rather than in university.”*

Julie’s tone was low and hinted somewhat disappointment. However, she was more delighted for the fact that she actually leant some cultural knowledge from the hospital where she had her clinical placement.

> Carrie answered: *“not many sit-down lectures but other modules such as ‘person-centred care’ touched on cultural awareness. It could have developed a lot more culture-focused teaching.”*

Carrie said in a calm and matter of fact manner. She expressed her expectations for a better teaching strategy on cultural competence from the university.

Abigale was a little upset because of a lack of opportunity for asking questions on cultural care, she said:

> *“Not sufficient cultural training. It will be good if more cultural training is available in university! No opportunity to ask questions such as ‘what do I do if I come across patients from different cultures?’*
>
> Salina also echoed: *“I don’t remember cultural training at all in university. I believe they should. I am from Nepal and I have been here 8 years, I am still adapting to different cultures.”*
>
> Olean agreed the fact that insufficient cultural teaching in the university by saying: *“nothing specifically on cultural training.”*
>
> Angela answered with frustration and almost angry tone: *“I have a big say about this! We don’t have enough cultural training, hardly any! The previous students didn’t have either. I could see from their behaviour that they didn’t have any cultural training.”*

Angela was angry when she highlighted her experience where qualified nurses undermined a patient's intelligence because he cannot speak English at a handover meeting. Her voice and facial expression revealed a strong belief that patient care could be compromised due to the cultural incompetency of the staff. Hence, the university was obliged to provide cultural training to student nurses to enable them to deliver competent care upon graduation.

The response from all participants confirmed that formal cultural competence training was not integrated into nursing training in the local university, which may be the key factor that resulted in inadequate cultural knowledge among student nurses. Evidence suggests that cultural training is widely variable in UK healthcare settings in terms of their content, duration, delivery and assessment (George et al., 2015; Bentley et. al., 2008). Moreover, cultural training has not been standardised or carried out in a consistent manner although an increasing number of professional guidelines, healthcare policies and statutory requirements encourage and even mandate this training (Workforce Race Equality Standard, 2015; Equality Delivery System, 2 2015). Since the inception of cultural competence as part of nursing curricula, the emphasis has been on future nurses becoming culturally competent. However, the literature on nursing faculty and cultural competency in the UK is limited.

Regarding cultural competence training in the university, seven (N=7) participants strongly expressed insufficient cultural training in their university and clinical areas, and expected more training to be integrated into their curricula to improve cultural competence awareness and competence. Whereas three (N=3) participants (Charlotte, Sarah and Smiri) were relatively content with their current nursing training because they focused more on their individual efforts by interacting with people from diverse cultural backgrounds. Nonetheless, those three participants also agreed that more cultural training could be integrated into their nursing training to further enhance their cultural competence.

Data analysis took the participants' personal information into consideration including their age, nationality, religion, and work experience. The analysis found age, religion did not affect their views of cultural competence, but nationality and work experience seemed to be associated with raised cultural competence level. It is worthwhile to

highlight that two of those three student nurses (Sarah and Smiri) who were relatively happy with the nursing training are from overseas (Jamaica and Nepal), and Charlotte was working as a Health Care Assistant (HCA) prior nursing raining. Even during the process of interviews, those overseas students appeared to be more interested in cultural competence discussions, and keen to learn, adapt, and develop their competent level. They seemed to be more sensitive to cultural issues and understanding the importance of cultural competence. While students who had working experience in health care field such as Charlotte seemed more confident with delivering culturally competent care; whereas others with previous working experience but not in the health care field were not as confident as Charlotte and Angela, but better than those who did not have working experience prior to nursing. Those findings suggest that overseas students and students who have health care working experience prior to nursing are more likely adaptive to different cultures, and more proactive in learning and developing cultural competence at personal level. This finding echoed Campinha-Bacote's (2002) statement that cultural competence can be learnt.

In this study, seven (N=7) participants stated that they were aware of diverse cultures but not sure what the differences were and how to gain understanding of the differences. For example: Olean said: "*I am aware of different cultures but not confident with every culture."* Furthermore, all (N=10) participants appeared to lack educational knowledge of cultural competence. Whilst three (N=3) participants were content with learning cultural competence at personal level, the majority (N=7) strongly expressed insufficient cultural training and believed the university to be responsible for their cultural competence development. In addition, all (N=10) participants expressed their expectations of structured cultural training from the university because they believed that their cultural competency could be enhanced through formal teaching. For example, Carrie stated: *"not many sit-down lectures but other modules such as 'person-centred care' touched on cultural awareness. It could have developed a lot more culture-focused teaching."* Abigale also said: *"not sufficient cultural training. It will be good if more cultural training is available in university!*

Cultural competence is a dynamic developing process that occurs on a continuum. It can be achieved through constant learning and practising (Campinha-Bacote, 2010).

Learning cross-cultural theories and practising when nursing culturally diverse patients require both HEIs and healthcare settings to facilitate the process of developing cultural competence. It has been suggested that healthcare professionals should continually learn and grow while attempting to engage in a process of cultural competency when working with diverse populations (Papadopoulos, 2016). Just like one of the participants Salina stated that:

> "*I have been here (in the UK) for 8 years, I am still learning and adapting with different cultures…"*

Cultural knowledge can be developed by seeking and learning information about cultures and requires self-assessment and knowledge of the patient's worldview (Campinha-Bacote, 2007). It involves understanding patient's language, their view of the world, the way their illness is perceived and the way they relate to their surroundings (Cutilli, 2005). The NMC (2014) recommended that nurses should search for the most accessible, factually reliable and culturally appropriate resources available, in preparing to care for culturally diverse population. Knowledge of the worldview of the population being served will assist in preventing unintended cultural offences, and help to establish a trusting healthcare relationship. According to LaVieist (2008) distrust between patients and healthcare professionals typically stems from miscommunication and misunderstanding of cultural values and beliefs. This mistrust affects patient compliance and interferes with quality outcomes. Therefore, it is crucial for health care professionals to understand patient's illness, particularly culturally understand patient's view of the illness, and effectively communicate with patients for making appropriate care plan. As such, patients' health care needs can be met. Nursing literature also suggests culturally competent nursing care education should begin at the student nurse level and restructuring the curriculum towards preparing a culturally competent graduate (Long, 2012). This study's finding suggested the need for the integration of cultural competence training into nursing curricula to meet student nurses' learning needs.

Becoming culturally competent is an ongoing process which requires constant learning and practising. This study finding revealed that student nurses' cultural competence could be enhanced through nursing education, clinical practice, as well as learning experience at personal level. It also showed that despite that all (N=10)

participants were motivated to learn and develop their cultural competence during their nursing training, their cultural knowledge was inadequate. In addition, formal cultural competence training was not included in the current nursing curriculum. It is, therefore, logical to conclude that student nurses' insufficient cultural knowledge is likely associated with the present inadequate cultural competence training in the university.

4.2.3 Theme 3. Clinical factors impacted on cultural competence

This study identified four key factors that impacted on developing culturally competent care in the clinical environment, which are staff shortages, language barriers, a poor learning environment, and cultural assessment was not involved in nursing care. Half of the participants (N=5) strongly believed that staff shortages on the ward, language barriers between staff and patients, and a poor learning environment are the main obstacles for them to develop cultural competence in clinical areas. Cultural assessment would provide essential information that potentially helps to deliver culturally competent care if it was included in nursing practice.

a. Shortage of staff

When I asked about the participants' clinical experiences of cultural competence, five (N=5) of them expressed their frustration of being unable to meet individualised care needs due to shortages of staff and language barriers in their clinical placement areas. For example**,** Abigale stated:

> "*I knew that an Islamic female patient would prefer to have a female nurse to help her for personal hygiene but there was not enough nursing staff on the ward at the time, so I had to ask a male nurse to help turn the patient to her side, this led to a big complaint against ward nursing staff from the family...".*

Abigale was somewhat upset when she described her experience. She strongly felt the limited resource and the lack of support from the organisation should be responsible for the situation she encountered rather than her individual capacity or skills. When I asked her what she had learnt from this experience, she said in future

she would tell the patient to wait until a female colleague was available. She pointed out that student nurse' learning needs could only be supported when there were adequate nursing colleagues on the ward.

Shortage of health care professionals is a concerning issue across NHS in the UK. According to a UK doctors' job satisfaction report (2019), of fifty percent (50%) UK doctors revealed that the most challenging factor is low staffing level in the national healthcare settings. Indeed, organisational structure shapes practice in a culturally diverse context because health care professionals must be content with them every day. These structures also frame the learning experience to the extent that they do or do not provide certain resources in healthcare settings. According to NHS Statistics (2019), there are nearly 94,000 full-time equivalent advertised vacancies in hospital and community services alone between July and September 2018. This equates to an estimated shortfall of eight percent (8%), that said around 1 in 12 healthcare posts is vacant. Among these advertised vacancies, the highest numbers are in nursing and midwifery. Obviously, the implications of these staff shortages were significant. The most direct impact was on the quality of patient care, and compromised staff training was also highlighted (The Health Foundation, 2019). It is necessary to address these concerning issues that compromised nursing training so that appropriate actions can be taken.

The study's findings suggest that staff shortage have not only negatively impacted on delivering culturally competent care, but also affected learning and job satisfaction among student nurses. To develop student nurses' cultural competence in clinical settings such as hospitals, multiple levels of support is required which include institutional teaching strategy makers, hospital education lead, ward mangers, mentors, and other qualified health care professionals.

b. Language barriers

One participant Angela was frustrated when she described her clinical experience of nursing a patient who did not speak English. She spoke to many health care professionals including a matron, trying to understand and provide the right care for that patient but failed because none of the staff spoke her language and no interpreter was available. Angela emphasised:

> "*Communication has to be the priority for patient care, if you can't understand what they say, how can you provide care?"*

She was waving her hands when she spoke, which clearly showed her frustration to the limited resources that resulted in poor patient care.

She then continued her statement but appeared to be a little disappointed:

> *"I wish I could pick up the phone and ring an interpreter just like we access porter service."*

I was in total agreement with Angela that effective communication is a key for nurses to provide appropriate care to patients. Research (Eklof et al., 2014) showed when there was misunderstanding due to ineffective communication between health care professionals and the patient, it would lead to barriers in accessing healthcare, and decrease in trust in the quality of care received and increased patient safety risk. Communication barriers can be a frustration for practitioners, resulting in difficulties with establishing interpersonal relationships to carry out the nursing role, which results in subsequently blaming the patient (O'Hagan, 2001). Although using an interpreter is a complex issue that involves taking into consideration aspects like ethical issues, there is the need for interpreter services which enable health care professionals to deliver culturally competent care irrespective of age, sex, ethnicity and religion. The importance of effective communication between health care professionals and patients has been repeatedly emphasised in the literature, and yet, that the use of a professional interpreter increases in the quality of patient care of people who speak a foreign language has not been well recognised at the organisational level. This study finding has illuminated Eklof et al.'s (2014) research findings which revealed that the inaccessibility of professional interpreters in service in health care settings is common.

c. Poor learning environments

It is recognised that good learning environments are important to foster cultural competence development (George et al., 2015). In this study, seven (N=7) participants said it was beneficial to learn diverse cultures from their fellow students who were from non-English cultures. For example, Charlotte said:

"*Students can learn from each other because we are from different cultures and no one takes offence about different ways people do things."*

Nine (N=9) participants recommended that frequent and repeated contact with people from other cultures raised their awareness of the challenges related to cultural values and beliefs, and also facilitated changes of their own views toward other cultures. Thus, they were more sensitive to examine their own attitudes and behaviour to patients from different cultures in the context of nursing practice. All (N=10) of the participants recommended that formal cultural training in the university could help them develop a cultural knowledge base, which was essential for coping with the complexity of care in a culturally diverse context. Among them, three (N=3) were content with cultural competence learning at personal level as they had profound personal and work experiences. Two (N=2) participants also stressed that in the clinical placement environment, hospital staff's support and their cultural diversity also influenced the progression of cultural competence from one level to the next. For example,

Smiri was very pleased with her clinical placement experience and her learning. She had smile on her face during the interview which indicated that she was content with her cultural competence learning. She described that her clinical placement was in the Intensive Care Unit where a few doctors and nurse were from abroad. They were friendly and supportive to her. They often looked after patients from diverse cultural backgrounds, and nurses always carried out effective communications with patients and relatives in a culturally sensitive manner. She said:

"*Hospital placement is beneficial (for cultural competence training) because both staff and patients are from different cultures so we can learn the difference from each other..."*

Angela said:

"*During handover (in the Acute Medical Unit where she had her clinical placement), if a patient is from non-English culture background, nursing staff would say 'oh, he doesn't speak English' with expression and voice of prejudice! (She frowned and waved her hands to emphasise that she*

did not like the qualified nurses' prejudice toward non-English speakers) No one makes efforts to help with communication and provides patient-centred care..."

Angela's exploration of her clinical experience had drawn some concerns such as 'prejudice' towards diverse cultural background patients. Although it was her personal view and could be judgmental, the fact that "*no one makes efforts with communication and provides patient-centred care"* was a disappointing phenomenon which had negatively impacted on Angela's learning of cultural competence. Student nurses' poor clinical experience indicated that clinical setting played an important role on their process of learning. The clinical environment is just as important as university for students to learn and practice because both organisations have shared responsibility to support the development of student nurses' cultural competence. This finding further illuminated the recommendations from the study (George et al., 2015) which suggests that cultural training for student nurses should also address the needs of the organisation and its employees to form part of an overall strategy in developing cultural competence. To overcome these challenges that impacted on culturally competent care delivery and cultural competence development, there is a need for a multi-faceted approach to create a good learning environment that fosters the development of cultural competence and its application in practice.

d. Cultural assessment is not included in nursing care plan

Cultural assessment is to acquire reliable data from the patient to enable nurses to create a culturally relevant plan for the individualised patient care (Campinha-Bacote, 2002). It is considered as an important part of the nursing assessment for all patients admitted to hospital in the US. However, this study revealed that cultural assessment was excluded in the nursing assessment in the local hospital. Sarah described the 'patient passport' where there is minimal information about patient's ethnicity and religion, "*but no one is interested in reading it even though it takes a second*" on the ward where she had her clinical placement. She also raised concerns that

"*Why don't nurses document properly about patients' cultural information such as language, religion, food preference, etc. so, we can provide better care to patients?"*

I could sense Sarah's frustration and totally understood her viewpoint. As a senior nurse I felt I must help to make Sarah's voice heard and change current nursing practice by including cultural assessment in nursing care plan. It was a very interesting finding that cultural assessment for the patients was not included in the nursing practice in the local hospital. Whilst in the US-based research, cultural assessment for all patients admitted to the hospital is a standard nursing practice, it appeared to be totally different in the UK. Based on my over 18 years nursing experience in the UK, I recall the only cultural information on patients' medical notes is about religion and ethnicity background, which is recorded by the clerk who works in the Accident and Emergency department. Even this minimal cultural information was sometimes ignored by the nursing staff because there were many more other documents and tasks that needed completing. It is obvious that not knowing patients cultural background has a potentially negative impact on developing student nurse' cultural competence, but most importantly, it could compromise patient-centred care, particularly for those from BAME backgrounds and non-English speakers. If excluding cultural assessment in the process of patient assessment is a common phenomenon across all UK hospitals, this finding would be significant to inform a change of nursing practice by including cultural assessment when making care plans for patients admitted to the hospital.

The details of cultural competence assessment content are displayed in Table 7. Those elements of cultural assessment were synthesised from the cultural competence models (Gigger and Davidhizer, 2008; Purnell, 2002; Campinha-Bacote, 2002; Leininger, 1998), which include first of all, language and ethnicity background, such as country of origin, what language is spoken; secondly, information about next of kin, how the patient prefers to involve the family for the care planning; thirdly, the worldview of the patient on interpretation of illness, how the illness or hospitalisation affects his or her life; fourthly, cultural values and beliefs; and finally, religious factors in terms of religion practice support, food preference, and whether or not the patient is happy to receive blood product for religion reasons. Those elements contain important information for planning individual patient care and help to meet individual's health care needs. The contents of the cultural assessment could be

potentially integrated into the nursing assessment process for patients admitted in the local hospital.

As this study is undertaken as part of the Professional Doctorate study there is an important requirement for the research to “further advance or enhance professional practice” (Lee, 2009, p.7). Therefore, this finding can be considered as evidence to inform change of practice by including cultural assessment in the nursing care plan.

Table 7: Cultural assessment contents

Elements of assessment	Contents
Language & Ethnicity	What is your country of origin? What is your ethnicity group? How long have you lived in this country? What language do you speak, read, and understand? Are there resources or equipment that you use to assist you with communicating? How would you like to be addressed while you are here?
Next of Kin (NOK)	Who is your NOK? Would you like him/her to be involved in your care? Any others would you like to be involved in your care? And how would you like for them to be involved? Are there barriers related to your family getting to hospital to visit you? Tell me what good care means to you? What can we do to make you feel that you are receiving good care? Do you feel safe at home? What will make you feel safe while you are here?
World view to health and illness	What does the word “healthy” mean to you? How will this illness or hospitalisation affect your life and life of your family? It can be frightening to be in hospital. What fears do you have about your illness? What disturbs you most about staying here?
Cultural values and beliefs	Are there any values/beliefs you would like for us to know about to help you to regain or maintain your health? How many meals do you normally eat? At what times? Tell me about the food that you normally eat at meal time? Are there any foods that you don’t eat ever or

	don't eat at certain times? What is your usual bed time? Is there anything helps you to sleep better or worse? What normally makes you feel better when you feel stressed?
Religious factors	Would you like someone to offer you religious support? Tell me your religious practice, e.g. Diet, prayer times, etc. Do you have preference for male or female to be involved in your care? Do you have restrictions about receiving blood?

4.2.4 Theme 4. Student nurses' recommendations on developing cultural competence

The final question in this study was:

> "In your view, *what can be done to develop or improve student nurses' cultural competence?*"

Six (N=6) participants strongly believed that the university should organise better overseas learning programmes to enhance their cultural awareness, knowledge, skills, encounter, and desire; they also highlighted that hospitals need to adopt cultural competence training for all the healthcare professionals because hospital staff's competency can influence students; Other different approaches were suggested, such as an information leaflet for different cultures. The six student nurses responded to the question in the following way:

> Sofi: "*Seminars, clinical placements abroad, and lectures on cultures definitely can help."*
>
> Julie: "*Simulation sessions, lectures, and clinical placement abroad program."*
>
> Abigale: "*seminars and going abroad to know different healthcare system."*
>
> Salina: "*seminars and learning abroad."*

Olean: *"information leaflet on different cultures are useful, teaching sessions in hospitals on cultures."*

Sarah recommended: "*go to cultural events or festivals organised by university is a good way to learn cultures."*

Student nurses from the UK felt the going abroad program was particularly helpful for their cultural competence training as they would have an opportunity to understand what it felt like as foreigners living in a different culture; whereas student nurses from abroad (N=3) (Angela, Charlotte, Simiri) felt fairly happy with cultural learning at personal level. The reason for this was that many of their fellow students were from diverse cultural backgrounds and they could learn diverse culture from one another. Interestingly, two out of the four participants (Angela and Charlotte) strongly believed that to gain cultural competence, student nurses should put more efforts at personal level rather than organisational or other individual's. For example, Angela believed:

"*Becoming culturally competent depends on the individual efforts and passion towards nursing and culture. If you are interested you will learn more."*

One mature student nurse, or participant Charlotte believed that her life experience of cultural encounters helped her more to gain cultural awareness, knowledge, skills and desire rather than learning from the university. Charlotte stated:

"*It depends on personal life experience. As a matured student, I have experienced different cultures in my family, so I am culturally competent but not everyone else is. I think personal experience is more important than learning in university".*

Different recommendations exist in literature in terms of how to achieve cultural competence. The literature (Vega, 2005; Bhugra et al., 2011) demonstrated that cultural competence could be learnt at a personal level but individual learning was not enough to guarantee a sensitive approach to cultural diversity, it needed to be achieved at levels of policy maker, service provider, and clinicians. In relation to this study, six (N=6) participants believed that cultural competence needs to be achieved at the levels of nursing educators, universities, hospitals, and student nurses. This

finding has challenged some research results. Studies from Sargent et al. (2005) and Sealey et al. (2006) showed high cultural commitment among staff and student nurses in nursing faculty by integrating Campinha-Bacote's model of cultural competence care as an assessment tool into nursing training program; Whereas other studies (Wellman, 2009; De Chesnay, 2012) suggested improving cultural competence is through retention and recruitment of culturally diverse faculty and students as well as curricular planning for students. Whilst introducing cultural competence programs that teach the skills and strategies necessary to address specific cultures, other methods of acquiring knowledge and personal experience about cultures, attitudes, values, beliefs and behaviour are also necessary to deliver patient-centred care. For example, group discussions, lectures, case scenarios, and studying abroad programs were recommended in this study. Long's study (2012) suggested that emphasis should be more on practical development of culturally competent care than on knowledge and theory. Practical aspect of cultural competence would require culturally competent nurse educators to teach and equip faculty with the needed knowledge and skills to understand cultural differences and then have effective cultural encounters in the clinical setting.

Current UK nursing training involves fifty percent (50%) in university learning and other fifty percent (50%) clinical. Hence, both HEIs and healthcare settings are equally important as learning environments to support student nurses for the development of cultural competence. The responsibility of designing and implementing cultural training for student nurses need to be shared by both organisations. Regarding learning or teaching strategy issues in this study, all (N=10) participants appraised the 3-month overseas program organised by their university and highly recommended its effectiveness to enhance their cultural competence. This finding correlates with other research results which showed cultural training, cultural programmes or cross-cultural programmes can influence students' learning and development of cultural knowledge, skills, and awareness, such as international opportunities (Long, 2016) and study abroad opportunities (Carpenter and Garcia, 2012).

If cultural competence needs to be integrated into pre-registered nursing curricula, then nursing educators are playing important roles for teaching cultural knowledge and skills. At the university level, nursing educators need to be prepared to advance

their own cultural competence in order to educate students. Some studies (Marzilli, 2016; Reju et al., 2014) support the fact that nursing educators are moderately culturally competent and able to serve as role models for students. However, they still need a comprehensive understanding of culture, cultural competence, and their own perceptions of the skills, knowledge, awareness, and sensitivity involved in caring for culturally diverse patients. Since student nurses spend much of their time on clinical placement in the local hospital, healthcare professionals' cultural awareness and competency level play an important role to positively influence student nurses' development of cultural competence. One participant Angela expressed:

> "*Even qualified nursing staff is lack of cultural awareness which obviously has negative impact on our training…"*

It is crucial that healthcare organisations become involved in creating environments that foster the development of cultural competence and its application in practice (Garneau and Pepin, 2015).This may suggest the need for the local hospital to consider cultural competence development strategies that could be incorporated into continuing nursing education for qualified healthcare professionals. As previously addressed current UK nursing training requires student nurses to spend half of their training time in faculty, and the other half in clinical settings. Therefore, the responsibility of providing cultural competence training needs to be shared by both the university and the hospital or other clinical settings. In addition, hospital qualified healthcare professionals' level of cultural competence also has a big impact on student nurses' learning process. It might be useful for the hospital to organise regular cultural training sessions for qualified nurses, especially for those who would be future mentors because their cultural competence level would, undoubtedly, influence student nurses' development of cultural competence. At an individual level, students' own cultural value and beliefs and personal experience may have a degree of influence on their cultural perceptions and behaviours. However, individual's learning is not enough to guarantee a sensitive approach to culturally diverse patient care (Vega, 2005). This study's findings suggest that the local university, hospital and individual students should work together to achieve the goal of cultural competence.

4.3 Summary

The research findings revealed four key issues. Firstly, All (N=10) student nurses were fairly confident with their culturally competent care delivery in their clinical practice based on their self-evaluations. Their cultural awareness, skills, desire, and encounters were relatively satisfactory. Understanding, respect, appreciation, and adaptation to different culture were the core value for the student nurses when nursing culturally diverse patients. All student nurses or participants believed good nurse-patient relationship was a central part of the cultural competence, and communication was the key to deliver culturally competent care. They also demonstrated that they were relatively equipped or able to respond appropriately to patients' cultural needs and preferences. However, all the participants appeared to be insufficient in cultural knowledge, and none of the participants was aware of the cross-cultural nursing theories or theorists.

Secondly, Cultural competence training was not included in the nursing curricula, and all participants expressed high expectations that formal cultural education needed to be integrated into nursing curriculum from the university. This indicated insufficient cultural knowledge among student nurses might be possibly associated with inadequate formal cultural training in the local university. While there exists current debate about which teaching or learning approach is most effective and efficient to enhance cultural competence in the context of health care settings, the participants from this study strongly believed a studying abroad programme, seminars and group discussions could improve their development of cultural competence. Understanding the cultural competence level and gaps in competency is an important step for the nursing faculty to gain some insights into the current capacity to teach cultural competence within full range of nursing programs (Diaz et al., 2015). This study has provided evidence for the local university to reform the nursing curriculum by adding knowledge relevant to diverse culture and cultural competence, such as studying abroad programmes, seminars and group discussions. This study findings also suggested that those students who came from overseas or had working experience prior to nursing were more likely to adapt to different cultures and more proactive to learn and develop cultural competence at personal level.

Thirdly, the study identified four clinical factors that impacted on student nurses' cultural competence including shortages of staff on the ward, language barriers and lack of interpreter services, poor learning environment and no cultural assessment in the nursing care plan. Half (N=5) of participants were concerned that shortages of staff in the hospital and difficulty of resources accessibility, such as unable to access interpreter services resulted in failure to meet individualised care needs. They believed the health care organisation should be accountable for the factors hampering quality of patient care. The study also revealed that whilst the university is accountable for student nurses' cultural competence training, since student nurses spend half of their training time in clinical settings such as hospitals, the health care settings are equally responsible with fostering the training process by providing a good learning environment where cultural competence can be developed. Concerns such as some qualified nurses were lacking cultural competence awareness which, subsequently, impacted on student nurses' training was also highlighted in the study findings. Two student nurses were concerned that cultural assessment was not included in the nursing care plan in the hospital where they practiced. As a result, patient care was, obviously, compromised. Since cultural assessments provide important information for designing and implementing individualised care, it has been a part of the nursing care plan in the US. In contrast, this study revealed that cultural assessment has not been formally embedded in the local UK hospital so far. If further studies demonstrated that this phenomenon is common across UK hospitals or primary care settings, then, this significant finding may inform the future change of nursing practice in the UK by including cultural assessment in the nursing care plan. Cultural assessment contents (Table 7) combined with personal, cultural, social-economical information of the patient can be used.

Finally, the study generated some recommendations for developing student nurses' cultural competence from student's perspectives. The findings suggested that multi-faceted approaches at a personal level, organisational level, and the level of nursing policy makers are required to overcome the obstacles that prevent student nurses from developing cultural competence. As such, student nurses' cultural competence can be developed and culturally competent care can be delivered upon graduation. Moreover, the study indicated that not only does cultural training, a cultural programme, or cross-cultural experiences can influence student nurses' learning and

development of cultural competence; but more exposure to diverse cultural encounters also enables stronger cultural desires to be developed. The study findings also revealed the overseas students and those who had work experiences prior to nursing training were more adaptive and confident to culturally competent care, whereas other participants were not so confident but showed great desire for developing cultural competence. Knowing that all student nurses are motivated to learn, adopt, and develop culturally competent care to patients from diverse backgrounds at a personal level, an emphasis needs to be placed on educational institutions and health care settings, such as hospitals. This study suggested that in terms of university responsibilities, integrating cultural training into nursing curriculum was one example, a studying abroad programme was another to support student nurses' cultural competence. The findings also revealed that cultural competency of all clinicians in health care settings had significant influence on student nurses' learning and developing cultural competence. The hospital, therefore, need to involve their frontline staff in the development and implementation of training regarding culturally appropriate care, as such, they are adequately prepared to teach and assess student nurses for cultural competence.

Chapter 5: Conclusion

5.1 Introduction

This final chapter draws together the conclusion from the research process of the study and subsequent findings. It highlights how the aim and objectives were met and the unique contribution of knowledge on student nurses' preparedness of cultural competence this study made. The study limitations are illustrated and further research is recommended. As this study is undertaken as a part of the Professional Doctorate, there is a requirement for the study to further enhance the professional practice (Lee, 2009). Therefore, a consideration of including cultural assessment in nursing care is highlighted as one of the recommendations of the study.

5.2 Conclusion of the study

In response to increases in culturally diverse populations in the UK, it is imperative to prepare student nurses for delivering competent care to all patients irrespective of culture backgrounds upon graduation. Cultural competence is a skill set required by all nurses, whether working in the community or secondary care settings. It is an essential element of clinical competence that enables nurses to deliver appropriate individualised care. Educational preparation may have provided sufficient opportunities to develop some but not all knowledge and skills required in the NMC code (2015) or considered pertinent to cultural competence (Douglas et al., 2014). The UK professional guidance in relation to respecting individual differences and valuing cultural diversity has tended to be primarily prescriptive without a clear statement on what should be happening and what it 'looks like' in practice.

The complex nature of culture concept and different terminologies used for cultural and cultural competence in literature caused somewhat confusion for understanding of cultural competency in health care settings. Additionally, a variety of cultural competence models exist, and their areas of focus and use are different. Although Campinha-Bacote's model has been mostly quoted in literature, the evidence of its efficacy and effectiveness to use in nursing education and practice in other countries beside US is relatively weak. As a result, the level of cultural competence education and practice is variable among HEIs and clinical settings worldwide including UK.

Some health care professionals are inadequately prepared for cultural competency, which leads to many clinical complaints and compromised patient care in health care settings that I have witnessed. As nurses are the main health care workforce and expected to deliver culturally competent care, nursing training plays an important role to enable student nurses to achieve cultural competency. Whilst plentiful research from US has demonstrated that nurses' cultural competence can be improved through training programme, it is not clear in UK nursing because the number of publications around this field of research in the UK is limited. This study has provided an opportunity to find out what local student nurses' perception and experiences of cultural competence are; what clinical and institutional factors impacted on their cultural competence; and what can be done to support the development of cultural competence.

The aim of the study was to understand student nurses' preparedness in their nursing training programme for delivering culturally competent care upon graduation. This study intended to achieve three objectives:

1. To critically explore student nurses' perceptions and experiences of cultural competence.

2. To identify factors of institutional and clinical nursing training impact on student nurses' cultural competence.

3. To offer recommendations for the progressive development of cultural competence from student nurses' perspectives.

In order to become culturally competent, understanding the concept of culture is first step. However, the nature of culture remains complex due to its contested characters which makes understanding culture difficult. There exist essentialism and constructivism perspective views of culture. An essentialist views culture as static and unchanging. Thus, cultural competence is focused on learning values, beliefs, and traditions of particular group and applying this knowledge to practice. In contrast, a constructivist perspective views culture as a socially constructed, dynamic and evolving process. Thus, cultural competence is an ongoing process involving transmitting and using knowledge that depends on dynamics in the community, society and global networks. Among all the cultural definitions, Purnell's culture

definition (2013) defined by its characteristics is the most comprehensive and useful for student nurses to understand the complexity of culture and its influence on people's values and behaviours (Chapter 1.1). Purnell suggests that culture contains two characteristics. One is generally unchangeable such as race and colour; the other is likely to change over time such as educational status, social economic status, and place of residency because they are influenced by life experience. Purnell's culture concept recognises both essentialist and constructivist perspectives of culture and highlights that both characteristics can influence people's thoughts and behaviours. By in-depth understanding Purnell's cultural concept, student nurses are likely to appreciate the complex nature of culture. Its changeable and unchangeable characteristics are influential on people's thoughts, behaviours, and values in different ways dependent on individual circumstances. As such, student nurses are encouraged to constantly learn, reflect, and practise; subsequently, gain necessary knowledge and skills that lead to competency when caring for culturally diverse patients.

Similarly, a variety of cultural competence concepts exist in the nursing literature. These depend on the views of culture, essentialist and constructivist perspectives: there are different focuses on cultural competence. There exist four influential cultural competence models in nursing literature. Of them, Campinha-Bacote's (2002) concept of cultural competence is mostly recognised worldwide due to its comprehensiveness, practicality, and applicability in diverse healthcare settings. It also recognises both static and dynamic nature of culture. Campinha-Bacote defines cultural competence as a process involving integrations of cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire. She later developed the concept further to a cultural competence care model, which has been used internationally with minor amendments. The five components of her cultural competence theory has been used as a framework for developing and implementing culturally competent care in the field of health care education and practice worldwide, and approved to be effective, particularly in US nursing. It provides roadmap for developing and assessing cultural competence in nursing education as well as nursing practice. Whilst health care system is different between US and UK, the helping role of enabling people to stay healthy remains the same as central to health care provision, and multiculturalism presents in both societies. Hence, the

theory can be used in the UK nursing with appropriate modification. It is for this reason, Campinha-Bacote's (2002) cultural competence care theory was chosen as a conceptual framework for this study.

This phenomenological study recruited ten student nurses with mixed cultural backgrounds. The findings revealed that participants' age, religion and sex did not affect their experience of cultural competence but nationality and work experience had a positive impact on their competency. Five overseas student nurses and three who had work experiences prior to nursing appeared to be more adaptive and confident to the development of cultural competence at personal level. This finding suggests that cultural competence can be learnt through personal or professional experience. The study demonstrated that all (N=10) participants were fairly confident with their culturally competent care delivery in their clinical placements, and their cultural awareness, skills, desire and encounter were relatively satisfactory. However, their cultural knowledge and understanding of cross-cultural nursing theories were insufficient. Seven (N=7) student nurses expressed that cultural training in the university was inadequate and expected formal cultural training to be integrated into their current nursing education curriculum to enhance their cultural competency. This indicated the likelihood of association between insufficient cultural knowledge among student nurses and inadequate cultural competence training in the local university. Seminars, overseas learning programs, and lectures were recommended by the student nurses as effective approaches to improve cultural competence from the university. Three (N=3) students also emphasised the level of cultural competence among qualified clinicians had huge influence on student nurses' cultural care in the clinical setting. Since student nurses were required to spend half of their nursing training in the clinical settings, it is crucial for the hospital to recognise the importance of cultural competence among all the staff and share the responsibility by organising appropriate training to support culturally competent care.

This study also identified four clinical factors that impacted on developing student nurses' cultural competence and delivering culturally competent care in their clinical placement. They were shortage of staff on the ward, lack of interpreter service, poor learning environment, and no cultural assessment for patients admitted to the hospital. The first three factors were considered to be the key issues that hindered the development of student nurses' cultural competence, which further illuminated

exiting studies' findings. Whereas the fourth factor was not revealed in any other up to date research, hence, is a unique contribution of the study. It is particularly significant for informing change of nursing practice in the local UK hospital by including cultural assessment in the nursing care plan when admitting patients to the hospital. The data collected from the cultural assessment (table 8) can be useful for designing appropriate care plan that meets individual patient needs.

To overcome those challenges, student nurses recommended that multi-faceted approaches at personal level, organisational level, and the level of nursing policy makers were required to achieve cultural competency among student nurses. This finding has echoed other existing research findings (Bhui et al., 2007; Bennett et al., 2009) which demonstrated that cultural competence training in isolation would change little; whereas approach at individual, organisational, policy and social level would make a difference. Moreover, it is recognised that not only can cultural training, cultural programmes, or cross-cultural experiences influence student nurses' learning and development of cultural knowledge, skills, and awareness, but also the more exposure to the diverse cultural encounters, the stronger cultural desires they develop. This study finding suggested that those overseas students and those who had pre-nursing work experience were more confident and adaptive to develop cultural competence. The study also revealed that all student nurses (N=10) were motivated to learn, adopt, and develop culturally competent care at personal level when nursing patients from diverse backgrounds, an emphasis was recommended to be placed on the HEIs and health care settings such as hospitals. To enable nursing training adequately prepare health care professionals to meet the needs of culturally diverse patients, the health care organisations need to involve their frontline staff to gain better understanding of current training needs regarding culturally competent care, and be sufficiently prepared to teach cultural competence. Since current nursing training programme is divided into fifty percent (50%) learning in HEI and fifty percent (50%) practice in clinical settings, both universities and healthcare settings are equally responsible for the support of developing cultural competence among student nurses.

In conclusion, there are four major findings that met the objectives set out for this study:

- Student nurses' cultural competence level is relatively satisfactory including their cultural awareness, skills, desire, and encounters. However, their cultural knowledge is insufficient in terms of educational base for culture and cultural competence theories.

- Formal cultural training is not integrated into nursing curricula in the local university, which has a possible likelihood link to student nurses' insufficient cultural knowledge.

- Four clinical factors impact on developing student nurses' cultural competence, including shortages of staff, language barrier and lack of interpreters, a poor learning environment, and no cultural assessment for patients admitted to the hospital.

- Student nurses' recommendations for progressively developing their cultural competence are to encourage working in partnership at multiple levels such as faculties, clinical settings, policy makers, as well as individuals. HEIs and healthcare settings are equally responsible for the support of cultural competence training to enable student nurses to achieve cultural competence upon graduation.

Whilst the majority of above findings are supported by evidence shown from up to date literature, one unique finding from this study is significant which may inform change of future nursing practice in the local UK hospital. The finding revealed that cultural assessment was not included in current nursing practice in the local hospital. The finding indicated that excluding cultural assessments not only had negatively impacted on student nurses delivering culturally competent care, but more importantly, compromised quality of individualised care, especially for those who were BAME backgrounds. This finding provided evidence for the need to add cultural assessments for every patient admitted to hospital, particularly, for those who are from ethnic minority cultural backgrounds and non-English speakers. The synthesised contents of cultural assessment based on four cultural competence models were illustrated in table 7, which can be used as guideline for patient's cultural assessment when planning nursing care. Another interesting finding was that overseas student nurses and those who had pre-nursing work experiences appeared

to be more adaptive and confident to learn and develop cultural competence at personal level in comparison with UK students and those without work experiences.

5.3 Limitations of the study

There are several limitations of the overall study. Firstly, in regards with using phenomenological approach and Colaizzi's phenomenological data analysis framework, I was fully aware the key focus of phenomenology was about interpretation of meanings of participants' feelings and experiences. Whilst the phenomenological questions of student nurses' cultural competence experience were the key for guiding the enquiry, to support final recommendations and offer a more practical application of theory to practice, thematic analysis could support a structured response that provided thematic contents. For this reason, thematic method was employed alongside of Colaizzi's phenomenological framework during the process of data analysis, as it has helped to provide a clear structure for organising themes of the research findings. In addition, my personal preference for the pragmatism of a clear structure influenced the presentation of the data which might have given readers the impression of a degree of deviation from pure phenomenology to a thematic method. Nonetheless, the research findings were grounded by participants' lived experience of cultural care training, and their interpretation of meanings of their experience was undoubtedly taken into consideration which is the essence of phenomenology. To avoid confusion, any future study will present more participants' thoughts and feelings in the data to meet the essential criteria of phenomenological approach for the research.

Secondly, in describing student nurses' cultural competence level, all students were recruited from only one of the London Universities. Whereas this particular university has inadequate formal cultural training in nursing curricula as described by the students in the study, other London or UK universities may have different teaching strategies and curricula. I have used a small sample of ten students, which is not necessarily representative of all of London or UK nursing training. Caution, therefore, should be taken in generalising these findings to other areas of London or UK universities that have different backgrounds. Suggestions for future studies may include bigger samples from multiple universities, for example, five students from

each university around the UK; participants from diverse cultural backgrounds; and also involving educators for the understanding of nursing curricula. It is suggested that educational interventions for developing student nurses' cultural competence should engage student nurses in caring patients from diverse cultures, such as clinical placement in different districts or community hospitals. It is also an effective way to improve cultural competence through enrolling more student nurses from diverse cultural backgrounds.

Thirdly, the study is limited by the timing of sample recruitment. As a result, the research sample was all female. The only two male students in the hospital at the time of recruitment did not fit the inclusion criteria as first year students, therefore, the sample showed strong gender disparity. However, the reason for a huge shortage of male nurses is because that nursing has been traditionally seen as a female career. Statistics showed only eleven percent (11%) of nurses in the UK were male by 2018 (Ford, 2019). Although more male nurses are needed to meet patient-centred care needs, readjusting the gender balance in nursing is still problematic around the UK and globally (Wish report, 2018). While the female students were from different cultural backgrounds and they did represent different views based on their own cultural influence, the research findings could be more comprehensive from both sex's perspectives if male student nurses were recruited. Future study could also involve patients for assessing their experiences of receiving culturally competent care as the goal of culture competence is to improve patient care and their clinical outcomes. Another limitation of sample recruitment is that I specifically asked for ten student nurses with an interest in the research topic to participate due to time constraint, therefore, the research findings based on their thoughts and beliefs are limited, hence, may not reflect the views of other student nurses. Future study will consider unbiased sampling process with larger numbers by randomly recruiting participants with or without interests in cultural competence in order to collect inclusive information. As such, the results will be more representative to the views of student nurse's population, and subsequently, enhance validity of the study.

The final study limitation is philosophical aspect of phenomenology. I audio recorded all ten interviews and made notes during the interviews. At the end of the interviews, I had summarised the participants' views with them to verify data interpretation. Although I aimed to be objective, minimising the bias by bracketing my feelings and

previous knowledge as what phenomenology requires, and also tried hard to analyse the data as the participants saw it, I was inevitably influenced by my own nursing experience and might not always be as precise as what they said. As a female practitioner researcher, I might have interpreted the data from a female perspective as well.

To overcome these limitations, future research may focus on larger samples across the UK universities including both male and female student nurses if possible; unbiased recruitment by random sampling; different age groups with variable working experiences; and involving educators to identify teaching, learning, and evaluation strategies for further development of cultural competence among student nurses. These may include strategies developed from HEI as well as clinical environment, such as hospitals. Further research may demonstrate the benefit of integrating cultural competence into nursing curricula throughout nursing training institutionally and clinically to enable student nurses achieve cultural competence upon graduation.

5.4 Recommendations of the study

The main recommendations of this study include, firstly, from nursing education point of view, the university and local hospital are recommended to work in partnership for forming appropriate learning, teaching, and evaluation strategies, such as identifying student nurses' learning needs on cultural competence; and integrating cultural competence training into nursing curricula. Campinha-Bacote's five components of cultural competence are valuable but may need amendments to be more specific and applicable to the context of local use. Consideration of the guidelines for implementing culturally competent nursing care (Appendix 5) is also recommended when forming the strategies. Furthermore, cultural competence is to be classified as additional layer to clinical competence. Student nurses require multiple level of support for learning and practising, as well as assessment to ensure they are prepared for delivering culturally competent nursing care upon graduation.

Secondly, In terms of student nurses' recruitment strategy, it is to encourage applicants from overseas as well as those who have pre-nursing work experiences,

particularly experience in the health care field as demonstrated from the study that they are more adaptive and proactive to learn and develop cultural competence.

Thirdly, in regards with current nursing practice, the recommendation is to include cultural assessment as a part of nursing care plan during the process of history taking for all patients admitted to the local hospital. Cultural assessment enables nurses to collect essential social and personal information in order to design and deliver individualised care, as such, patients' needs can be met. If NMC (2014) requires all nurses to be able to provide patient-centred care regardless of their cultural backgrounds, then, cultural assessment is an important data collection process to enable individualised nursing care that cannot be missed.

Finally, from research perspective, further research around cultural competence among student nurses in the UK is to be encouraged. Research results will provide evidence for developing cultural competence, and subsequently improving quality of individualised care. The emphasis will focus on identifying effective teaching, learning, and evaluation strategies. HEIs and health care settings are to be included as both organisations are responsible for supporting the learning, practising, and assessing cultural competence among student nurses.

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Appendix 1: Participant Invitation letter

Name:

Address:

Date:

Name of the study: Phenomenological study of student nurses' preparedness for delivering culturally competent care upon graduation

Dear student nurses,

I am writing to invite you to participate in a piece of research, which will be conducted in St. Helier Hospital focusing on understanding of culturally competent nursing care training and student nurses' experiences of delivering such care in the wards. It is a study that forms professional doctorate degree at the University of Salford.

Aim of the study: the study aims to critically examine student nurses' preparedness in their nursing training for delivering culturally competent care upon graduation.

Research method: It is a qualitative study by using semi-structured interviews. Participants will be interviewed individually for 30-40 minutes in the hospital medical ward meeting room. Interviews will be conducted during your working time at your convenience. Tape recorders will be used and data will be transcribed by the researcher.

Inclusion criteria: 2nd and 3rd year student nurses, who had or have experience of working in hospital or community settings; who are interested in participating in a research study of above topic.

Exclusion criteria: 1st year students who have not had sufficient clinical experience; and student nurses who are not interested in or not willing to share their experience and perception of above topic.

Your participation is important for the study findings and they would potentially raise awareness of culturally competent care amongst all health care professionals.

However, I understand you may have questions about the study and your involvement. Please read enclosed documents which are aimed to answer your queries. If you find you still have more questions following reading the documents, please do not hesitate to contact me on the details provided on the information sheet.

Yours Sincerely,
Xxxxxx
Professional doctorate student in the University of Salford

Appendix 2: Participant Consent Form-interview

Title of study: Phenomenological study of student nurses' preparedness for delivering culturally competent care upon graduation

Name of Researcher: xxxxxxxxx

Please complete and sign this form after you have read and understood the study information sheet. Read the statement below and circle Yes or No column to indicate your response.

1	I confirm I have read and understood the participant information sheet (V3. 04/02/18) for the study. I have had an opportunity to consider the information and ask questions.	Yes	No
2	I understand that my participation is voluntary and I am free to withdraw from the study at any time, without giving any reason, and without my rights being affected.	Yes	No
3	I am aware that if I decide to withdraw from the study, information I have provided, up to the point of withdrawal, will still be used in the research.	Yes	No
4	I agree to participate in an individual interview which will be recorded on a tape recorder.	Yes	No
5	I understand that my personal details will be kept confidential and only the researcher has access to the information I provide. I am happy to participate and understand that my confidentiality will be maintained. My name, place of study and work will be kept anonymous. I also understand that if poor practice is disclosed the researcher has an obligation to report this to my clinical tutor and ward manger and complete an incident form (Datix).	Yes	No
6	I understand that my anonymised data will be used in the researcher's thesis and will also be used in academic publications, teaching, and conference presentations.	Yes	No
7	I agree to take part in above study.	Yes	No
8	I would like to receive a summary of the findings from this study.	Yes	No
9	I understand that the data I provide will be used anonymously for the research only. I have been explained that dissemination methods of the research and data will be destroyed after the research.	Yes	No

_____ _____ _____

Name of participant Date Signature

_____ _____ _____

Name of researcher Date Signature

Appendix 3: Semi-structured interview questions

1. What does “cultural competency” mean to you? How do you interpret the phrase?

2. What was your clinical experience like where you looked after a patient whose cultural background was different from yours? Do you think you have provided good care that met his/her needs?

3. Could you explore it? Do you think you have handled it well and why? If not, what would you have done differently to improve the outcome?

4. What was your cultural training like during your nursing training from both the university and the clinical setting?

5. How well do you think you are equipped during your nursing training to enable you to provide culturally competent care for patients from different cultural backgrounds?

6. In your opinion, what more can be done during your institutional and clinical nursing training to develop your cultural competence?

Appendix 4: An analytical process chart

Yellow-pseudonym of participants

Red-interview questions

Green: personal views which are not included in the main themes but will be discussed in research finding chapter

Analytical stages	Analytical process	Actions
Stage 1	Acquiring a sense of each transcript	Review 10 participants interview transcript several times in order to get a sense of the data as a whole
Stage 2	Extract significant statement	Participant 1(Sofi): Q1: what your clinical experience was like where you looked after a patient whose cultural background was different from yours? -surgical patient (African male) refused for blood transfusion; -"religious reason" -"Doctors and nurses explained everything to the patient but he still refused to accept…" -"respect their choice, can't force them" -"great appreciation on what other cultures are and what they do..." Q2: What does Cultural Competence mean to you? "Understanding other cultures and what you can do to care about them" Q3: what was cultural training like in the university and clinical areas? -"Not sufficient training, no one tells you about how to care about patients from different culture when it comes to healthcare environment, you have to find out yourself…" -"some modules mentioned about odd things but not in details…" -"when you see people around you from different cultures do things differently, you go "wow" and realised you have to adapt…" Q4: What more can be done to improve cultural competence, in your view? -"Seminars on cultures among students because students are from different countries… help to adapt the way you think…" -"arrange clinical placement abroad to understand different cultures and how people do things differently..." -"teaching/lectures on culture definitely helps..."

		Participant 2(Julie from Nigeria): Q1: What your clinical experience was like where you look after a patient whose cultural background was different from yours? -“An Italian patient who couldn’t speak English, couldn’t communicate…” -“He used IPad for translation… it is important to spend time with him, treat patient individually…” -“be open-minded and friendly…” -“I am used to different cultures because I am Nigerian. I am interested in other cultures and respect other cultures, keen to learn other cultures…” -“people from ethnic minority tend to appreciate more about different cultures because we have seen more cultures and adapt to other cultures…” Q2: What does Cultural Competence mean to you? -“you want to learn other cultures, respect and share what you know to be able to provide appropriate care. Nurses have to be culturally competent because it is the world we live in nowadays…” Q3: What was cultural training like in the university and clinical areas? -“not a lot. University has not got into culture yet. I think I leant more in clinical practice rather than in university. Q4: What more can be done to improve cultural competence, in your view? -“Add on cultural training into teaching, for example, simulation sessions can correlate with some culture issues, lectures can be added on as well…” -“clinical placement abroad program is useful but it should be better organised by the university rather than leaving it for students to do ourselves. I planned to go abroad for three weeks but could not organise everything myself, so now I have to stay in London…” Participant 3 (Carrie): Q1: What your clinical experience was like where you looked after a patient whose cultural background was different from yours? -“a Pakistani female patient who couldn’t speak English… difficult to establish nurse-patient relationship without communication.” -“sat on her bed site, tried to use body language, be friendly with her…learn their language… spend time and engage with her…” Q2: What does Cultural Competence mean to you? -“knowledge of different cultures, have some general ideas in order to care people. Do more research; be aware of other cultures as well.”

		Q3: What was cultural training like in the university and clinical areas? -“Not many sit-down lectures but other modules such as ‘person-centred care’ touched about cultural awareness; it could develop a lot more culture-focused teaching…” -“students can learn more about cultures in University rather than realise it later on by yourself.” Q4: What more can be done to improve cultural competence, in your view? -“Placement abroad is useful because it is interesting to learn how healthcare system works everywhere else…If university could organise and fund for students it would be better…” -“more interactive discussions on cultures can be helpful as well.” Participant 4 (Abigale): Q1: How your clinical experience was like where you looked after a patient whose cultural background was different from yours? -“An Islamic male who preferred his wife to do personal hygiene for him rather than nurses.” -“spoke to his wife and she was happy to come to hospital to help him. Sometimes it is better to involve family for the care.” -“initially I felt odd but then I realised his religion and belief, Then I saw him same as others and no judgement…” -“I am aware of what I am saying, people from same culture I can speak light-heartedly but not with people from different cultures.” Q2: What does Cultural Competence mean to you? -“Understanding, awareness and adaptation of different cultures. Knowing what they are individually and the role of nurses to them.” Q3: How was cultural training like in the university and clinical areas? -“Not sufficient cultural training, it will be good if more cultural training is available in university.” -“no opportunity to ask questions such as what do I do if I come across people from different cultures?” Q4: What more can be done to improve cultural competence, in your view? -“Seminars, more interactive discussions help to develop understandings of different cultures.” -“Going abroad program helps to develop confidence for a particular culture but impossible to learn every cultures, university can cover more cultural training.” -“Appreciation and understanding cultures can be achieved in England because we are multi-cultural

		society, especially in London." -"White people and ethnic minority people are equally aware of culture difference but ethnic minority people maybe more adaptive because they are already in a different culture themselves." Participant 5 (Salina from Nepal) Q1: How your clinical experience was like where you looked after a patient whose cultural background was different from yours? -"A patient who spoke Urdu not English at all." -"I spoke a little bit Urdu so she was keen to talk to me." -To me, doctors and nurses in that ward could have done more but they did not help much, they didn't even get an interpreter…" -"They could have used body language, verbal and non-verbal communication skills to get a good patient-nurse relationship, be friendly and tried to help… this had very negative impact on her care…" -"I spend time with her and asked her what she needed, etc. When I left the ward, she cried. Reflect on the experience, I thought I am not going to do the same as the other nurses and doctors." Q2: What does Cultural Competence mean to you? -"having the knowledge, what is appropriate, what is not. Remind yourself that not everyone is the same." Q3: How was cultural training like in the university and clinical areas? -"Not sufficient, they can add on one module for cultural awareness or seminars." -"I don't remember cultural training at all in university. I believe they should. I am from Nepal and I have been here 8 years, I am still adapting different cultures." Q4: What more can be done to improve cultural competence, in your view? -"Seminars are useful because people can discuss things; people become more aware of different cultures because we are from different countries. -"Going abroad program will improve culture competence but University needs to do more to help. At the moment, there is lack of cultural training in university." Participant 6 (Olean): Q1: What your clinical experience was like where you looked after a patient whose cultural background was different from yours? -"not particular incident that I can remember, I know food preference and expectations from different cultures, otherwise nothing massively different." -"I am aware there are different cultures but not confident

		with every culture” Q2: What does Cultural Competence mean to you? -“Ability of knowledge, ability to adapt culture differences. Accept the way it is with different culture.” Q3: What was cultural training like in the university and clinical areas? -“Nothing specifically in cultural training. One module on ‘person-centred care’ touched on different cultures. I think it is a good start. Students can learn from each other because students are from different cultures.” Q4: What more can be done to improve cultural competence, in your view? -“Information leaflet about different cultures, shared learnings of cultural issues in University; even online learning can be useful too.” -“Seminars can be helpful because interactions between students.” -“in hospital environment, 1-2 hours teaching sessions about cultures can be useful.” Participant 7 (Smiri from Nepal) Q1: What your clinical experience was like where you looked after a patient whose cultural background was different from yours? -“An Islamic male patient was reluctant to communicate with female nurses. I realised it is maybe due to his religion or personality.” -“I tried to talk to him every time I passed by him and asked him if there was anything he needed, etc. After a week I looked after him, he started talking to me and smiled to me.” Q2: What does Cultural Competence mean to you? -“every patient is different. Their views, beliefs, values should be respected. Understanding their culture is important. Being professional as well as understanding them at personal level.” Q3: What was cultural training like in the university and clinical areas? -“No formal cultural training but university appreciate who are you and encourage everyone to express what you need and support you.” -“I think current nursing training would enable me to become culturally competent up to 90% I’d say.” -“University and hospital environment can help for cultural competence.” Q4: What more can be done to improve cultural competence, in your view? -“Seminars in university can make difference because students are from different cultural background and it helps to understand different cultures.”

		-“Hospital placements are beneficial too because both staff and patients are from different culture background so we can learn the difference from each other.” Participant 8 (Charlotte): Q1: What your clinical experience was like where you looked after a patient whose cultural background was different from yours? -“A Jamaican lady who is outspoken and strong personality. She was upfront, not rude but just her culture… She made me feel I am not good enough.” -“I went home and spoke to my sister and brother-in-law, he is Jamaican. He said that’s their culture, women are like that. I went back to the patient and appeared to be more confident and upfront to her. Knowing she tended to use shower room first in the morning, I helped her to follow her routine…she became very friendly in the end…” -“Knowing the patient as an individual in order to provide care is important.” -“it is important not to forget care and compassion as a nurse.” Q2: What does Cultural Competence mean to you? -“Your competency in knowledge and information you have in regards with the patient you care for. Speak to the patient, find out their religion, routine, treat patient individually, even if they are from the same culture, they may be different. You need to adapt to different patient.” Q3: What was cultural training like in the university and clinical areas? -“There is no specific module for cultural training but some elements of culture integrated throughout the teaching in university.” -“It depends on personal life experience. As a matured student, I have experienced different cultures in my family, so I am culturally competent but not everyone else. I think experience is more important than learning in university.” Q4: What more can be done to improve cultural competence, in your view? -“I think current nursing training has given opportunities to interact with people from different cultures and support learning needs for students… it is good as it is.” -“ Seminars maybe helpful, students can learn from each other because we are from different cultures and no one takes offence about different ways people do things.” Participant 9 (Angela, from Bambina Guinea) Q1: What does Cultural Competence mean to you? -“I think cultural competence is being able to care people from diverse cultures and competent in caring for them, mainly language barrier.”

		-“Of course, other things like cultural belief and dietary preference, and other difference between English and other cultures...” I: “have you read any cultural competency articles or research?” -“No, I haven’t read anything of them. I haven’t seen anything published from here.” Q2: What your clinical experience was like where you looked after a patient whose cultural background was different from yours? -“I am culturally different from people here. I am open-minded to different cultures. I think we should communicate through body language if there is language barrier. Body language is universal language. You can tell straight away that somebody is confused or in pain. We ned to take time with them, not to rush things. I always look for the next of kin to find out more information such as what they like to eat, do they prefer tea rather than coffee, etc.… we need to provide specific care to the patient.” -“I am from Bambina Guinea, I was there until 21. I was healthcare assistant in England for 6 years before I start nursing training.” -“I don’t think ethnic minority is more aware of cultural diverse but up-bring experience is more important than race background.” Q3: What was cultural training like in the university and clinical areas? -“I have a big say about this. We don’t have enough cultural training, hardly any. The previous students didn’t have either. I could see from their behaviour that they hardly had any cultural training. For example: during handover, if someone if from another culture background, nursing staff would say “oh, he doesn’t speak English” (with expression and voice of prejudice). No one makes efforts to help with communication and provide patient-centred care…” -“Maybe it is due to multi-factors such as no staff, lots of tasks for nurses to complete, lack of interpreter service in the hospital, lack of education, and lack of communication between staff, etc.” Q4: What more can be done to improve cultural competence, in your view? -“In an idea world, I wish we can pick up the phone and ring interpreters just like how we access porter service.” -“communication has to be the priority for patient care, if you can’t understand what they want, how can you provide care? And also, patient has right to know what is

		going on, what we are doing and why." -"I think we should have language ambassador on each ward who is responsible to find out each patient's information. University education will not be effective because we are more influenced on the ward in the hospital. If ward staff are not aware of cultural diverse we will be negatively influenced." -"Overseas learning program is helpful for cultural awareness and competence." -"It also depends on the individual's efforts or passion towards nursing and culture. If you are interested you will learn more." Participant 10 (Sarah, from Jamaica) Q1: What does Cultural Competence mean to you? -"It means understand other individual's cultural background and provide person-centred care." -"Standardised care is not appropriate for everyone. We should be able to deliver person-centred care to that specific patient." Q2: What your clinical experience was like where you looked after a patient whose cultural background was different from yours? -"I looked after a Muslim female patient. She didn't speak English. She needed personal care at that time. I was not expert to Muslim culture but aware that they are very private… but we only had a male Health Care Assistant (HCA) to help me for her personal care. So we started washing her. Her husband came and saw a male HCA washing her so he was very angry. I had to apologise and explained that we were short of staff and no female staff available to help, etc. He stated that he did not want this happen again…" -"Reflected on it, I felt that I should have tried to find a female HCA from other wards instead of having the male HCA to help. I definitely won't do it again. I learnt my lesson." Q3: What was cultural training like in the university and clinical areas? -"cultural training is embedded in some modules such as person-centred care. There is not a module for culture. -"we need self-taught for cultural knowledge and awareness. I am a student ambassador. I can go to a lot of cultural events or festivals. It's better to have some personal experience of other cultures. The university is very much culture divers." Q4: What more can be done to improve cultural

		competence, in your view? -“Go to cultural events or festivals organised by the university; add a cultural module for us to learn; lecture is not as effective as small group discussions, such as seminars.” -“AMU (acute medical unit) is lack of culture awareness, culture is part of the assessment, actually some patients have ‘patient passport’ where there is cultural information on it but no one is interested in reading it.” -“As an individual, we should be mindful of other cultures, treat everyone as an individual.” -“University should provide opportunities to reflect and discuss about cultural issues. What have we seen outside of the university?” -“As a student, it is hard to challenge even if you have seen something is not right, but learning cultural knowledge is beneficial for making changes after graduation.
Stage 3	Formulation of meanings	Participant 1(Sofi): clinical experience of a surgical patient from Africa refused to receive blood transfusion due to religious reason. This experience has made S realised it is important to respect patient’s religion and choice; and understand and appreciate different cultures in order to provide appropriate care to them. There is insufficient cultural training in university, students have to learn themselves. S suggests university to organise seminars, lectures and overseas’ placement to raise awareness of cultural competence in nursing. Participant 2 (Julie from Nigeria): clinical experience of an Italian patient who has language barrier but managed to communicate with IPad translation. J is from Nigeria. J feels people from ethnic minorities like her are more open-minded and friendly with patients from different cultural background because they are more adaptive to different cultures. It is important to learn, respect and share your knowledge to be able to provide appropriate care to patients from different cultures in today’s nursing. J feels university has not done much about cultural education for student nurses, she learnt more from clinical placement. J suggests adding on a module specifically for cultural awareness or simulations sessions to nursing training. J was disappointed that placement abroad program was not organised properly by the university, as a result she had to stay in London instead. Participant 3 (Carrie): Clinical experience of a Pakistani lady who couldn’t speak English. C feels communication (verbal or non-verbal, body language and caring attitude are useful) is essential for nurse-patient relationship. C spent time and engaged with the patient and gained trusty

		relationship from the patient. C believes cultural knowledge, even some general idea of cultures is important to deliver care to patients from different cultures. C expressed that although some modules involve cultural issues but more teaching regarding culture can be organised in university in order for students to learn beforehand rather than realise by themselves later upon graduation. C expects University could organise better regards with placement abroad program and some discussion sessions. Participant 4 (Abigale): clinical experience of involving family members to look after an Islamic male patient. A didn't understand his behaviour initially but later realised it was due to his religion and belief so she treated him same as other patients. A is sensitive to cultural difference and aware of her own behaviour towards individuals. A believes understanding, awareness and adaptation are important for a nurse to deliver culturally competent care. A thinks there is lack of opportunity to raise concerns of cultural issues and no specific cultural training in university. A believes placement abroad program can help for cultural awareness but not the only way, university could organise more discussion sessions to raise cultural awareness and university itself is multi-cultural hence students can learn from each other. A thinks local people is same as ethnic minorities in terms of culture awareness but ethnic minorities are more adaptive because they are already in different culture. Participant 5 (Salina from Nepal): clinical experience of caring a patient who can only spoke Urdu. Sa by chance spoke some Urdu so she used her limited languages skills and body language to establish a good nurse-patient relationship. Sa was disappointed that other healthcare professional were not trying hard to provide care the patient needed. This experience reminded Sa that as a culturally competent nurse she should have cultural knowledge and treat patient individually in future practice. Sa believes university should do more for cultural competence training for everyone such as discussion seminars and placement abroad program because cultural awareness is an on-going process, even for those who are from other cultures like herself. Participant 6 (Olean): Not a particular event was recalled but O seems to think no massive difference between different cultures besides food and expectations. O believes cultural knowledge, adaptation, and acceptance enable cultural competence as a nurse. O expressed no specific culture training module is available but is content with current nursing training because students are from different countries so they are learn different cultures from

		each other. O suggests from university point of view, seminars, leaflets and online learning are useful to raise awareness of cultural competence; from hospital, 1-2 hours discussion sessions can be helpful too. Participant 7 (Smiri from Nepal): clinical experience of caring for an Islamic male patient who didn't talk to female nurse much due his religion or personality. Sm's caring attitude and body language helped to establish a good nurse-patient relationship and he started to talk to Sm after a week. Sm believes a culturally competent nurse should respect patients' views, religion, beliefs, and values and treat them individually because they are different. Sm Believes current nursing training is good enough to enable her to be culturally competent upon graduation because both university and hospital placement have provided good multi-cultural environment for her to learn and become culturally competent. Participant 8 (Charlotte): looking after a Jamaican lady whose behaviour is challenging and made Ch uncomfortable. After reflection, Ch changed her behaviour to meet the patient's needs which achieved a good outcome. Ch felt knowing the patient and treat them individual is important, never forget care and compassion as a nurse. Ch believes knowledge, adaptation, and individual care are essential to be a culturally competent nurse. Ch is confident with her own culture awareness and competency because her own life experience. She believes life experience is more important than learning in the university for culture awareness.Ch is happy with current nursing training on culture competency as to some extent culture is integrated throughout the nursing training and the university students are from different cultures so they learn from each other. Participant 9 (Angela): language barrier seems to be her major concern in culture context. An's 6 years HCA experience gave her lots of insights of practical issues in clinical placement. An believed interpreter is essential to improve communication between staff and patients who is from divers culture. An strongly believed that cultural training in nursing education is lacking and even qualified nurses are lack of cultural awareness which has negative impact on her clinical experience. An suggested to develop easy access of interpreter in hospital would help improve culturally competent care; and encourage family involvement for collecting data for culturally diverse patients. In terms of faculty, An suggested to have language ambassador to improve communication, overseas learning program, and individual efforts for culturally competent care. Participant 10 (Sarah): Sar believed understanding other

		cultures and being able to provide person-centred care is cultural competence. Sar's experience of looking after a Muslim patient had made her realised sensitivity of care provider's sex to the patient and appreciated the religion belief. Sar believes to become culturally competent one has to be self-taught and pay efforts. Sar suggested to attend cultural events held by university; add on a culture module; seminars; overseas learning are helpful from university point of view. Hospital qualified nurse should be more culturally competent as well.
Stage 4	Organising formulated meanings into clusters of themes	Sofi: • Respect patient's religion and choice • Understand and appreciate different cultures • Insufficient cultural training in university, learnt more in clinical placement • Suggests seminars, lectures and overseas placement Julie: • To be open-minded and friendly • To learn, respect, and share cultural knowledge • Lack of cultural training in university, learnt more in clinical placement • Suggests to add a module for culture awareness, and organise overseas placement better • Ethnic minorities seem more open-minded and friendly, and more adaptive to patients from different cultures Carrie: • Communication (verbal and non-verbal), caring attitude, spending time and engaging with patients are important elements for Nurse-Patient relationship • Cultural knowledge and general idea of different cultures help to deliver culturally competent care • Although some modules touched culture issues, more teaching can be done in university • It is better to learn culture competence in university rather than realise yourself later after graduation • Expects university to organise overseas placement better Abigale: • Being non-judgemental when caring patients from different cultures • Understanding, awareness, and adaptation are important for cultural competence • Lack of opportunity to make enquires about culture issues, and no specific cultural training in university • Suggests to organise discussion sessions and

		encourage students to learn from each other in university • English people are as equal as other ethnic minorities for culture awareness, but minorities are more adaptive because they are already in a different culture. Salina: • Utilise language skills and body language to engage with patients from different culture can help Nurse-patient relationship • Cultural competence means cultural knowledge and treating people individually • Lack of cultural training in university • Expects more to be done to improve cultural competence for everyone even those who come from different cultures as learning cultures is a long process. Overseas placement should be better organised by the university Olean: • All patients are not massively different besides food and expectations • Knowledge, adaptation, acceptance are important to deliver appropriate care • Content with current nursing training • Encourage students to learn from each other. leaflets, seminars, and online learning are useful to raise cultural awareness in university; 1-2 hours cultural training sessions in hospital can be useful too Smiri: • Caring attitude and body language help Nurse-patient relationship • Cultural competence means respect patient's views, beliefs, religions, and values • Happy with current nursing training because students are from different cultures so they can learn from each other; hospital environment is multi-cultural too Charlotte: • Knowing patient individually and be adaptive to meet their care needs • Cultural competence means knowledge, adaptation, and individuality • Happy with current nursing training because students are from different cultures and they can learn from each other • Life experience regards culture is more important than learning form university

		Angela: • Cultural competence means being able to care culturally diverse patients and competent in caring for them • Language barrier is a key issue in cultural competence • Lack of cultural training in nursing education • Suggests multi-facets cultural awareness is required in order to improve cultural competence among student nurses including hospital, university and individuals. Sarah: • Cultural competence is to understand other cultures and provide person-centred care. • Appreciate and respect cultural or religion belief. • Personal experience and efforts are important to enable student nurses become culturally competent. • Suggests individual efforts are important to gain culture knowledge, but hospital and university also require improvement to positively influence student nurses become culturally competent.
Stage 5	Main themes	• Clinical experiences: Respect, understand, and appreciate different cultures including religions, beliefs, and values. Treat people individually because everyone is different. • Perception of culture competence: cultural knowledge, understanding, awareness, and adaptation are important elements to be culturally competent in nursing context. • Nurse-patient relationship: verbal and non-verbal communication, caring attitude, spending time and engaging with patients help to establish a good nurse-patient relationship. • Cultural training in university: 6 participants expressed lack of cultural training in university. They suggest seminars, lectures, and overseas placement program are helpful for cultural awareness and improve competence. Some also suggest students to learn from each other because they are from different cultural backgrounds. • To achieve cultural competence among student nurses, university, hospital and individual students need to work together to raise cultural awareness.
Stage 6	Further reduction of main themes	• Clinical experiences: respect, understanding, appreciation, individuality. • Perception of culture competence: knowledge, understanding, awareness, and adaptation.

		• Nurse-patient relationship: communication, caring attitude, time, and engaging. • Cultural training: several approaches such as seminars, lectures, overseas learning program can be integrated to current nursing training. • It requires multi-facets efforts to enable student nurses become culturally competent upon graduation.
Stage 7	Returning to participants (debatable)	Not yet required to return to participants at this stage.

Appendix 5: Guidelines for Implementing Culturally Competent Nursing Care

1. Knowledge of cultures guideline involves 5 topics which would assist for culturally competent nursing care: the impact of cultural attitudes, values, traditions and behaviours; health seeking behaviours of culturally diverse individuals, families, communities, and populations; impact of communication style of individuals, families, and communities; the impact of health policies on culturally diverse populations; resources can be used for culturally diverse populations.
2. Education and training in culturally competent care guideline suggests that cultural training should be an on-going process to enhance nursing students' awareness of cultural competence care and enable their cultural competency upon graduation.
3. Critical reflection guideline addresses the importance of understanding one's own cultural beliefs and values as well as culture of others, thus one can critically analyse, examine, and appreciate the impact of diverse cultures on individuals' values and behaviours.
4. Effective cross-cultural communication guideline demonstrates respect and, dignity, and preservation of human rights (Miller et. al, 2008). Therefore, good communication skills such as eye contact and body language are essential to comprehend diverse patients' health care needs. It also suggests that health care system should make every attempt to provide recourses for interpretation for patients from different cultural backgrounds.
5. Culturally competent practice guideline states that cultural competence requires cultural knowledge, skills, attitudes, and interest in learning and reflecting on variables of cultures. Those attributes should be congruent into nursing education to enable nursing student s to gain cultural competence in future professional practice.
6. Cultural competence in health care systems and organisations guideline explained that organisational decision making, programme development, and information exchange leads to the quality of cultural competent care that may result in improved patient health outcomes.
7. Patient advocacy and empowerment guideline remind professional nurses should act as patients' advocates by facilitating patients' voices for their needs

and concerns. This required nurses to respect culture based values, beliefs, and behaviours of patients from diverse cultural backgrounds.

8. Multicultural workforce guideline suggests that cultural competency is required to recruit and retain multicultural workforce in the health care system. Many of them would bring their cultural knowledge that will benefit fellow colleagues as well as patients.
9. Cross-cultural leadership guideline pointed out that leadership promotes implementation of culturally competent care and facilitates cultural research and integration of research into practice that leads to further development of cultural competence.
10. Evidence-based practice and research guideline encourages professional nurses to provide systematically tested, clinically useful and effective interventions for culturally diverse populations.

Appendix 6: Ethics approval (copy)

University of Salford MANCHESTER

Research, Enterprise and Engagement
Ethical Approval Panel

Research Centres Support Team
G.03 Joule House
University of Salford
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk/

9 March 2018

Dear Qun,

RE: ETHICS APPLICATION–HSR1617-185 – 'Student Nurses' experiences of delivering culturally competent care within elderly care wards.'

Based on the information that you have provided, I am pleased to inform you that application HSR1617-185 has been approved.

If there are any changes to the project and/or its methodology, then please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

A. Clark

Dr. Andrew Clark
Deputy Chair of the Research Ethics Panel

Appendix 7: Participant's Information Sheet

Study Title: student nurses' experiences of delivering culturally competent care within elderly care wards

Name of Researcher: xxx

Invitation paragraph

I would like to invite you to participate in a research study, which is forming part of a professional doctorate at University of Salford. Prior to you agreeing to take part in the study, it is essential that I provide with relevant information so you can understand the reasoning for the research and what your involvement will be. Please take a few minutes to read this information sheet before making up your mind about whether or not you would like to participate with the research. Feel free to ask questions if you are unclear on any of the study or require any more information. My contact details and my supervisor's details are located at the end of the form.

What is the purpose of the study?

The aim of the study is to evaluate student nurses' perceptions on their cultural competence in clinical practice through exploration of student nurses' experiences of delivering culturally competent care within elderly care wards.

Do I have to take part?

No, you do not have to take part. Your participation is voluntary. If you do not wish to participate you do not have to do anything in response to this request. I ask you to take part in the research because I believe you can provide information relevant to the research in cultural competence amongst student nurses.

What will I do if I take part?

If you are happy to participate in the research I will ask you to read this information sheet, sign the consent form and return to me. When I receive this form I will then contact you and discuss your participation regarding date and time that are convenient for you to participate.

The study employs interviews as the data collection method. You are invited to participate in a one to one interview lasting approximately 45-60 minutes. This interview will be conducted at your place of work to minimise your inconvenience at a time this is convenient to you. I will contact you to arrange an appropriate time for interview. Interviews will be recorded on a tape recorder and then transcribed and maintained confidentially.

What are the possible disadvantages and risk of taking part?

Possible distress might occur during the interview. If you do become distressed, interview will be stopped and tape recorder will be turned off unless you are willing to continue. You will be offered a break and psychological support through counselling services if it is necessary (contact details of local counselling service and GP practice are provided as below). Should poor practice occur this will be raised with your line manager and an incident report (Datix) will be completed. Additionally, if there are any safeguarding concerns safeguarding alerts will be raised.

What will happen to the result of the research?

The result of the research will be available in one or more of the following resources: nursing journals; regional conferences, local hospital meetings. Thesis will be available online through the University.

What are the benefits of participation of the research?

Your participation will provide useful information on interpretation and perception of cultural competency among student nurses. Research findings will help to identify what can be done to enable student nurses to become culturally competent upon graduation.

Will the information provided by me be kept confidential and anonymised?

All information provided by you will be kept confidential and anonymised at all times. No personal details relating to you or where you work will not be recorded anywhere. All paper data collected such as filed notes will be stored in a locked draw in a

locked room; electronic data will be stored in a password protected computer in a locked office, accessed only by the researcher.

Who is the researcher?

I am one of the Professional Doctorate students. I am the only researcher who is undertaking this research study. The research will be authorised by University of Salford and Queen Elizabeth Hospitals NHS Foundation Trust Ethics Committees.

What if there is a problem?

If you have any concerns, please contact my supervisors whose details are at the end of this form.

If you remain unhappy and wish to complain formally, please forward your concerns to Professor Susan McAndrew, Chair of the Health Research Ethical Approval Panel, Room MS1.91, Mary Seacole Building, Frederick Road Campus, University of Salford, Salford, M6 6PU. Tel: 0161 295 2278. E: s.mcandrew@salford.ac.uk'

Who is organising or sponsor the research?

The study is being conducted as a part of the Professional Doctorate programme, by a student at the University of Salford.

Further information and contact details:

Researcher: xxxxxxx

Supervisors: xxxxxxx

Xxxxxxx