

“One Size Does Not Fit All” - Undergraduate Nursing Students’ Perspectives of
Intercultural Communication: A Qualitative Descriptive Study

By

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Abstract

Problematic communication in nurse-client relationships is a contributory factor to healthcare disparities, health inequity, systemic racism, and negative health outcomes. Introduction of intercultural communication (ICC) in nursing education is vital to equip the future health workforce. However, gaps exist in the literature regarding exploring undergraduate nursing students' perspectives of ICC which is crucial in determining the effectiveness and appropriateness of incorporating ICC in nursing curricula. Employing the Integrated Model of Intercultural Communication Competence as a guiding framework, the study explored the perceptions of undergraduate nursing students regarding ICC in their nursing program. Using a qualitative descriptive design, a purposive sample of fourth-year nursing students (N=10), who have completed a cultural diversity/communication course and were willing to participate in a 45-60-minutes interview, were recruited at a western Canadian university. Following ethics protocol, semi-structured, one-on-one interviews were conducted, digitally-recorded, transcribed verbatim, coded with NVivo, and analyzed using content analysis. Multiple data sources, report of study procedure, verbatim transcription, and member-checking were used to ensure rigor. Findings indicate limited ICC content in nursing curricula; however, the inclusion of ICC content in the nursing curriculum was perceived to facilitate more empathic care and participants reported that they were more open to elicit information and plan culturally safe care for all clients. Other findings prompt individual and system level changes including the integration of a cultural component in the health assessment process, while more active teaching strategies may be adopted to equip students with the requisite skills and knowledge for effective ICC. A revised ICC model is proposed. This study is significant in informing literature, curricula, clinical practicum, diversity inclusion, ICC policy, and further research.

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Finally, I express my most profound appreciation to God for His grace, wisdom, and strength which has brought me this far.

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Dedication

I dedicate this thesis to:

Nii Oshipi William Armah and Comfort Tetteh.

Dad and mom, you have always believed in me and supported me in my education. I say a big thank you and ‘ayekoo’ (well done) for all your toils. I truly love you.

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My love for life, words cannot express how much I appreciate your love and support.

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Chapter One: Background to the Study

This chapter provides a description and context of the subject matter and the basis for the research purpose, question, and its significance. In furtherance to that, details of assumptions to this study and the definitions of constructs to the study have been highlighted. The chapter concludes with a summary statement of the study's background/ problem, purpose, and the research question.

Globalization, immigration, and cultural diversity

Nursing education has experienced transformation over the past few decades to incorporate information on cultural diversity, which has resulted from globalization and migration (Bischoff, Kurth, & Henley, 2012). Cultural diversity refers to a variation of individuals' attributes extending beyond race, age, and gender, which include, but are not limited to the following: age; sex; race; ethnicity; sexual orientation; gender identity; family structures; geographic locations; national origin; immigrants and refugees; language; physical, functional, and learning abilities; religious beliefs; and socioeconomic status (American Association of Colleges of Nursing [AACN], 2017; Australian Bureau of Statistic, 2016). Most developing countries have encouraged immigrant and refugee placements to increase their population and as well, relieve immigrants of war, health problems, and financial burdens (Douglas et al., 2014; Statistics Canada, 2008). These factors have contributed to a growing diversity among western industrialized countries like Canada, thereby making Canada's socio-demographic statistics a multicultural one (Statistics Canada, 2016).

Canada, currently, records over 250 ethnic origins, 21.9% foreign-born population, 22.3% visible minority (includes immigrants and refugees) and 6.2% Aboriginal population.

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These percentages are multiplying (The Daily: Statistics Canada, 2017). For instance, the Aboriginal population was recorded to be 4.3% in 2016 which has increased by 1.9% during the 2016 census. Aboriginal people in Canada contribute to the richness and diversity of Canadian cultural heritage. The 2016 census recorded 2.1 million Aboriginal people of three main Aboriginal groups; First Nations (North American Indians: Cree, Mi'kmaq, and Ojibway were the most common ancestries)-1.5 million people, Métis ancestry was reported by 600,000 people, and Inuit ancestry was reported by 79,125 (The Daily: Statistics Canada, 2017).

Between 40.1 and 47.7 million culturally diverse people are estimated to live in Canada by 2036 (Statistic Canada, 2010). Consequently, the increase in cultural diversity among the population has related challenges in every sector of the economy. Health care, a significant segment of national development, faces the challenge of delivering healthcare efficiently to culturally diverse clients, as well as meeting the needs of a diversified health workforce (Buchan & Aiken, 2008).

Challenges with healthcare delivery

Communication. There is growing evidence of increasing inequalities in access to health care and health outcomes among culturally diverse populations worldwide (Australian Institute for Health and Welfare [AIHW], 2015; Quine et al., 2012). Health care providers may have the technical skills and medical knowledge to care for patients but may lack specific knowledge on the various cultural groups as well as the sensitivity of incorporating cultural factors to ensure the most appropriate care is given to each patient (University of Ottawa website, 2018). These can lead to cultural incompetency which shows gaps in their attitude and communication with culturally diverse clients.

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Intercultural communication (ICC) refers to the exchange of information or engagement in dialogue among people of different cultures (Okech et al., 2015). Miscommunication and misunderstanding while delivering healthcare have triggered concerns and dissatisfaction with healthcare among healthcare providers and culturally diverse patient groups (Quine et al., 2012). Communication problems may cause communication anxiety and fear of making mistakes even among nurses (Gerrish & Griffiths, 2004). Problematic ICC leads to misdiagnoses, delayed health services, prolonged hospitalization, death, loss of financial resources, and stereotyping (Sloots et al., 2010).

Discrimination and racism. Bigotry and racism have built-in effects on healthcare access, health inequities, and health outcomes on patients (Blanchet, Brown, & Varcoe, 2018; Krieger, 2014; Solar & Irwin, 2010). Anti-racism and anti-racist pedagogies, like the critical antidiscriminatory pedagogy (CADP), are needed in nursing education to combat this problem and develop the capacity of future and practicing nurses to counteract racism and discrimination of any form in healthcare delivery (Blanchet et al., 2017). The Indigenous Health Alliance (IHA) group is working on raising awareness of the differences in quality between the care that Canadian and Indigenous patients receive and to actively eliminate these differences (HealthCareCAN, 2016).

Recently, the media advocated for a racism-free Canada because the country has become known as one of the worst countries with racial problems and more culturally diverse people continue to migrate into this country (Macdonald & Steenbeek, 2015). Many Aboriginal peoples do not trust, and therefore do not use mainstream healthcare services because they feel unsafe from stereotyping and racism during their encounters with western healthcare professionals [HCPs] (AIHW, 2015; Health Council of Canada, 2012). The media reports on

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Brain Sinclair's death, an Indigenous person, who was ignored for over 34 hours in an Emergency Room is an example of a tragic outcome associated with stereotyping and systemic racism (Canadian Broadcasting Corporation [CBC] News, 2014; Canadian Television Network [CTV] News, December 2014). Anti-racist pedagogy or processes in nursing education is capable of informing nursing students of the critical determinants of health inequities, such as derogatory culture or race-based comments which may be evident in their interpersonal interactions with patients. Knowledge of such factors may facilitate change in their attitude and actions to increase cultural safety in health delivery (HealthCareCAN, 2018; Krieger, 2014, Varcoe, Browne, & Ponic, 2013).

Indigenous health and the Truth and Reconciliation Commission. Indigenous people have experienced a long history of systemic oppression through colonization and cultural assimilation which has precipitated distrust for non-Indigenous populations and the health care system (Goodman et al., 2017; Loppie, Reading, & de Leeuw, 2014; Vogel, 2015). The “Calls to Action” by the Truth and Reconciliation Commission (TRC) of Canada seek for avenues to redress the legacy of residential schools and promote the process of Canadian reconciliation (HealthCareCAN, 2016). According to HealthCareCAN (2016), these actions (specifically numbers 18-24 and 55) have a direct effect on promoting Indigenous health outcomes. The purpose of the TRC is to: “reveal to Canadians the complex truth about the history and the ongoing legacy of church-run residential schools...” and, “guide and inspire a process of truth and healing, leading toward reconciliation within Aboriginal families, and between Aboriginal peoples and non-Aboriginal communities, governments, and Canadians generally” (Truth and Reconciliation Commission of Canada [TRCC], 2015, p. 27).

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The Commission defines reconciliation as, “an ongoing process of establishing and maintaining respectful relationships” (TRCC, 2015, p.16). Whereby relationship building involves communication which is a dialogue between two parties. The demonstration of understanding of TRC’s call to action by healthcare professionals concerning the perspectives of Indigenous people access to healthcare is critical in demonstrating respect and repairing damaged trust. The 24th recommendation specifically states the “call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism” (TRCC, 2015, p. 211). The impact of the TRC recommendations in improving the health of Indigenous people shows the need to educate healthcare professionals on Indigenous peoples’ history and how to enhance communication with them during health care delivery.

Entry-level competencies for nurses. Some immigrants and refugees also experience stereotyping and systemic racism in health care (Statistics Canada, 2008). Recently, Canadians have accepted Syrian refugees, and the influx of immigrants through various immigration processes call for immediate actions towards cultural awareness and sensitivity. Targeting health professionals’ education towards this focus will equip the future health workforce and current practitioners to incorporate cultural perspectives in medical care while engaging clients in respectful communication and culturally safe health care delivery (University of Ottawa website, 2018). Nurses who make up a more significant segment of HCPs (48%), need to be acquainted with cultural competency education and this is part of their expected entry level

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competencies (Aboriginal Nurses Association of Canada [ANAC], Canadian Association of Schools of Nursing [CASN], & Canadian Nurses Association [CNA], 2009; CNA, 2015; CNA, 2019; College of Registered Nurses of Manitoba [CRNM], 2013; Registered Nurses' Association of Ontario [RNAO], 2007; World Health Organization [WHO], 2009).

The CNA outlined some responsibilities for stakeholders in healthcare delivery to facilitate an improvement in the cultural competency of nurses (CNA, 2010). It urged all nurses to acquire and incorporate cultural competencies in their relationships with clients and co-workers (CNA, 2010). Thus, the various institutions in which health providers work need to create environments that value and promotes cultural diversity: cultural awareness, sensitivity, and safety. Educators in academic institutions were also tasked to integrate concepts of cultural competence and diversity into curricula and promote cultural competence within the faculty and the student populations. Patient populations also had to decipher what information they share with healthcare providers (for instance, cultural beliefs) that will impact their health care. The responsibility for patients can be implemented through effective nurse-patient interactions that shows awareness, understanding, respect, and value for one's culture (CNA, 2010).

Communication in health care delivery. Effective nurse-client interactions increase patient satisfaction, adherence to medical instructions, voluntary informed decision making, and reduced hospital stay (Larsson, Sahlsten, Segesten, & Kaety, 2011). These outlined benefits imply that the addition of cultural perspectives in nurse-client communications may provide better relationship and health outcomes. It is, therefore, vital for academicians in healthcare education to consider equipping the upcoming generation of HCPs with the needed information on cultural diversity and ICC. Introduction of ICC in curricula, as a strategy to enhance the cultural competency of students from various disciplines, has been proven to be effective

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(Rupel & Brahms, 2014, p. 970). However, much is unknown about the impact of introducing ICC to undergraduate nursing students.

Larsson and colleagues (2011) reported that personal behaviors of nurses are sometimes determinants of patients' engagement in nursing care, as well as patients' response to treatment and access to health care. Their study revealed that some nurses do not encourage patient verbal input during ward rounds, drug administration, or in the planning of patient care. However, when patients' views are sought and utilized in nursing care planning, they felt involved in the decision-making process making it easier for them to partner with health providers and accept the care being provided to them (p. 3). Personal values, the context of interaction, and one's cultural background can influence one's communication skills (Fall et al., 2013; Jonasson & Laurant, 2012; Okech et al., 2015; Oliveira, 2013; Stadler, 2013). The manner of interaction (verbal or non-verbal) can make clients feel either welcomed, ignored, stigmatized or discriminated in their presence. Attitudes of some HCPs may be influenced by their cultural nurturing (the way of life by which are brought up), their value for people, and or social status (Okech et al., 2015) or their encounter with diversity education (Pacquiao, 2007).

Cultural/ diversity education. Diversity education has no explicit definition, but various terms like multicultural education, culturally responsive pedagogy or antiracist education have been used to describe different sections of diversity education (Nieto, 2019). Multicultural education was defined as a "philosophical concept built on the ideals of freedom, justice, equality, equity, and human dignity as acknowledged in various documents, such as the U.S. Declaration of Independence, constitutions of South Africa and the United States, and the Universal Declaration of Human Rights adopted by the United Nations" (National Association of Multicultural Education [NAME], 2019). Multicultural education increases productivity,

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overcomes the prejudice, develops interpersonal communication, creates cultural awareness, and prevents social conflicts (Ameny-Dixon, 2013). Hence diversity education may enlighten these HCPs (especially from the students' level) to overcome their prejudices, value clients, communicate respectfully, appreciate patient preferences and decisions, and build trusting relationships (Barbee & Gibson, 2001; Wright & Tolan, 2009). There has been an introduction of concepts of ICC in culture-related and communication courses within nursing curricula; however, there is a dearth of research that focuses on strategies that could improve ICC in nursing education (Gelfand et al., 2007). In furtherance to this, the concepts and impact of ICC have rarely been explored or evaluated in nursing education. Most studies focused on how to address diversity among students and faculty (Bednarz, Schim, & Doorenbos, 2010). Knowing the perspectives of undergraduate nursing students on ICC in their nursing program is essential in enlightening faculty on the impact of such courses on students' knowledge, skills, and abilities, and or the need for curricula revisions.

Purpose of the Study

Nurses require appropriate communication skills - both therapeutic and intercultural to interact with diverse clients in various contexts (Riley, 2008). Recommendations have been made globally to incorporate culturally-centered information in college students' curricula to better prepare them for a diversified population (Deardorff, 2015, p. 3).

Although most undergraduate nursing curricula worldwide have been revised to convey the message of diversity, limited information is available on ICC, which may or may not be embedded in the curricula. There is a gap in the literature concerning exploring perspectives of undergraduate nursing students to evaluate the effectiveness and appropriateness of

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incorporating ICC in nursing curricula. Education about ICC is surmised to be embedded in both didactic and experiential learning in nursing curricula (Philips, Manias, & Woodward-Kron, 2015, p. 2634). ICC information and practice sessions are posited to offer undergraduate nursing students the knowledge and skills needed to provide quality care to culturally diverse clients (Seckman & Diesel, 2013).

Thorpe identifies that an understanding of the impact of an intervention on student education is vital to address gaps in the literature, guide faculty to use more engaging student-centered approaches, and guide curriculum revisions (2004, p. 340). This process of intervention evaluation is comparable to an appraisal of a nursing education program. Both are beneficial to faculty and students in the short and long term. Faculty may know and teach culturally sensitive topics like ICC and what the students are expected to do (Montenery, Jones, Perry, Ross, & Zoucha, 2013). However, knowing the views of nursing students on the subject matter, their experiences, and their suggestions for improvement will enable faculty to develop more engaging student-centered approaches to facilitate better outcomes (Von Ah & Cassara, 2013). For example, student reflection after ICC practice may promote a better understanding of the impact of an intervention, theory, or information (Gustafsson & Fagerberg, 2004; Mann, Gordon, & Macleod, 2009).

These critical issues of stereotyping and systemic racism within the current health care system, along with a paucity of published research relating to the impact and evaluation of ICC in nursing education programs provided the researcher with the impetus to undertake this qualitative descriptive study.

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The purpose of this study was to explore the perspectives of undergraduate nursing students on ICC in their nursing education program. It further examined how their exposure to ICC in the nursing curricula impacted their abilities to care for culturally diverse patients, families, and communities.

Although qualitative descriptive studies are the least theoretical of qualitative methodologies (Sandelowski, 2000, p. 337), the five conceptual domains of the Integrated Model of Intercultural Communication Competence (IMICC) guided this study. This ICC model was developed by Arasaratnam and Doerful (2005). The next chapter provides more details about the model.

Research Questions

The research questions are:

1. What are undergraduate nursing students' perceptions of ICC in the nursing education program?
2. How has exposure to ICC in the nursing curricula impacted undergraduate nursing students' abilities to care for culturally diverse patients, families, and communities?

Significance of the Study

Although limited studies have been identified about ICC in nursing education, evidence from other disciplines demonstrates the tremendous impact of ICC education on students and professions (American Counseling Association [ACA], 2014; Singh, Merchant, Skudrzyk, & Ingene, 2012; Cornett-DeVito & McGlone, 2000; Ying & Ying, 2012). However, every discipline's approach to ICC varies and these variations in teaching strategies may influence the

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outcome. While some literature outlines the benefits of ICC, these researchers do not provide detailed information of what it entails, how to implement it, or the validity and reliability of evaluation tools (Singh et al., 2012, p. 10).

Nurses require effective communication with clients, families, and other health care professionals (Bramhall, 2014; Fakhr-Movahedi et al., 2011). By understanding the intercultural aspect of nurse-patient communication, the dreams, and fears of students, and what they think is beneficial to help them address the challenges in their interaction with culturally diverse clients, advanced measures can be taken to promote effective teaching strategies and curriculum revisions.

ICC is a complex concept that needs to be understood, used, and evaluated. It is vital in breaking communication barriers between interdisciplinary health workers and between nurses and clients. Nurses are usually the front-line HCPs who spend much time caring for their clients. Hence, being knowledgeable about ICC can make students culturally aware, humble, sensitive, and competent to address concerns raised by culturally diverse clients, colleagues, and even faculty (Campinha-Bacote, 2002). More evidence is needed to determine best strategies to facilitate effective ICC in nursing educational programs. This study's findings provided evidence to address the gap and enlighten faculty and education leaders.

This study was relevant in:

1. Identifying the barriers and facilitators of ICC in undergraduate nursing education programs.

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2. Providing an understanding of the perspectives of nursing students on their ICC experiences and the benefit of ICC education towards their future professional nursing practice.
3. Assisting faculty to identify the ICC educational needs of student nurses as well as the gaps in curriculum and the expectations of students and clinical practice.

Assumptions

Qualitative descriptive research has the philosophical assumption that “human beings make sense of their subjective reality and attach meaning to it” (website, p.7). This assumption enables the researcher to explore their worldviews or explanation of their experiences (Magilvy, 2003, p. 123; Sandelowski, 2010). Sandelowski and Barroso (2003a) and Tong, Sainsbury, and Craig (2007) contends that qualitative descriptive research helps to explore the complex experiences of nurses, policy makers, clients, and other health providers. An insight shared by Magilvy and Thomas (2009, p. 299) implies that qualitative descriptive design is restricted in its choice of research question, sample size, data generation and analysis methods, and the interpretation of the data that is generated. According to them, such limitations does not allow a “clear description of a specific phenomenon or experience from the perspective of the experiencing” participant (p. 299). This assertion means that the researcher only plays a partial role in interviewing the participant to solicit their views and reflection, rather than actively or objectively interpreting the data collected. Reporting and data analysis should be based on the current or initial rich data gathered from participants (Streubert-Speziale & Carpenter, 2007).

Further to the above, Sandelowski (2010) asserts that qualitative research methodology, irrespective of it’s being viewed from a realist or constructivist paradigm or approaches, usually

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find their basis on “factist” perspectives. This view implies that the realities presented by participants are factual and contain elements of truthfulness. Likewise, this inference also means that all preconceived thoughts or assumptions of the researcher may guide the interviewing. However, to prevent bias in reporting participant responses or in the content analysis, those pre-conceived feelings and knowledge must be sidelined before data analysis begins. It must be noted that I am a graduate student, as well as an international student from diverse cultural backgrounds. This may influence my perception of ICC from a student point of view. Therefore, a reflective journal will be used during data collection and analysis to highlight preconceived thoughts and assumptions.

I assume that ICC education equips students with cultural awareness, desire, sensitivity, and confidence to approach and safely care for diverse populations. This assumption is in alignment with Campinha-Bacote’s model of cultural competence and Benner’s model of clinical skills acquisition (Benner, 1984; Campinha-Bacote, 2007). Both describe the stages of proficiency levels of competence or skill development as a process. I believe that knowledge obtained from ICC educational strategies will guide students in their clinical decision making or judgment and interactions while delivering care to culturally diverse clients. It is incumbent on faculty to ensure that nursing students are not imposing their western medical knowledge or lauding the nurses’ power to make decisions for their clients. All interactions must be beneficial to both parties without any fear of harm to the client. While the researcher is not researching to implement such rules or ethical responsibilities, study participants will share their experiences which may present such contextual experiences.

These assumptions have been influenced by my interactions with clients and culturally diverse student nurses. ICC among nurses and their clients is a crucial issue which generates

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many assumptions, and therefore needed to be rectified and intervened. Awareness of these assumptions propelled an interest to find evidence to support my data interpretation and findings.

The researcher assumed the following:

1. Diverse viewpoints exist regarding ICC in healthcare delivery; likewise, there are various ICC educational strategies within health care professions.
2. Some nursing students encounter difficulties while integrating their theoretical knowledge of ICC into practice.
3. Understanding the experiences or perceptions of student nurses is vital for faculty in preparing their teaching strategies or curriculum designs.

Definitions of the Main Constructs

Qualitative researchers suggest a clear definition of the main concepts to avoid a misunderstanding of the construct, and for clarifying meanings (Vivar, et al., 2007). Moreover, clarification of the meaning of the key constructs ensures transparency of the study and allows the researcher to understand the specific context of the phenomenon under study. Main constructs for this study are defined in this section.

Culture. In this study, I adopted Gray and Thomas' definition of culture as it is a complex relational process which is receptive through an understanding of one's history, experiences, power relations, and gender (2006). In this study, I extended the definition of culture to include the processes that happen between individuals and groups within organizations and society, and that confer meaning and significance (Varcoe & Rodney, 2009,

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p. 141). It is the knowledge, beliefs, and values shared by members of a society. Often shown in its traditions, language, literature, art, music, and is passed on from generation to generation through the process of socialization (University of Ottawa website, 2018). Language is highly diverse globally and in context, communication is inevitable without languages, making culture a central aspect of communication (Yueqin, 2013, p. 5).

Cultural competency. I defined cultural competence in a similar manner to the Canadian Nurses Association (CNA) in that cultural competency is the application of knowledge, skills, attitudes or personal attributes required by nurses to maximize respectful relationships with diverse populations of clients and co-workers (CNA, 2010).

Cultural diversity. Diversity refers to "any attribute that happens to be salient to an individual that makes him/her perceive that he/she is different from another individual" (Friday & Friday, 2003, p. 863). According to RNAO, cultural diversity is the variation of cultural factors between people (RNAO, 2007). Foley and Lahr (2011) describe the inter and intra variations in cultures that create diversity. They further indicated that there is more diversity within a culture than between cultures (Foley & Lahr, 2011). For the purposes of this study, cultural diversity is a perceived variation of cultural factors between people.

Cultural safety. Cultural safety is defined as, "an outcome that is based on respectful engagement which recognizes and strives to address power imbalances inherent in the health and social services system. It results in an environment free of racism and discrimination where people feel safe receiving health care." (First Nation Health Authority of British Columbia, 2016, p.5). It is also believed that cultural safety promotes greater equity in health and health

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care as it is predicated on understanding power differentials inherent in health service delivery and redressing these inequities through educational processes (CNA, 2010).

Intercultural communication (ICC). Intercultural implies ‘between culture.’ Therefore, ICC refers to the exchange of information or engagement in dialogue among people of different cultures (Okech et al., 2015, p.270). Also, Huang et al. (2012, p. 37) present a constructive definition of ICC as “the act of sociality between different cultures.” In both definitions, there is the iteration of interaction between different cultures, which implies that every culture is unique and diverse personalities need to accept and understand each other to socialize meaningfully. In all contexts, effective communication is highly necessary to provide quality and safe nursing care (Kourkouta & Papathanasiou, 2014).

Perspectives. I adopted the Cambridge English Dictionary’s definition of perspectives as “a particular way of considering something” (Cambridge University Press, 2017).

Undergraduate nursing student. It is a title of any student undertaking a Bachelor of Nursing degree. These students are enrolled in an undergraduate nursing program. Hence, they have not taken any national professional nursing exam.

Chapter Summary

In this chapter, the researcher provided the background to the study which supports the relevance of exploring the perspectives of undergraduate nursing students on ICC. The increasing cultural diversity of users of the healthcare system has prompted the need to revise curricula, incorporate diversity pedagogies, and to educate nursing students in ICC for better health care delivery. However, no literature had explicitly examined ICC from the nursing students’ perspective. This chapter stated the study purpose, research questions, and the

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relevance of studying this subject matter. Additionally, the researcher's assumptions were highlighted after which the main constructs were defined to facilitate a better meaning of the subject matter.

Chapter Two: Review of the Literature

This chapter provides a review of the literature that is fundamental for this study. It gives an overview of the concept under study-ICC, its integration in undergraduate nursing education programs, and a summary of the empirical evidence related to the topic. The information provided in this section also highlights the gaps identified from literature which propelled the need for this study. An in-depth literature review offers a foreknowledge of what other researchers have done in concerning the study, positions the intellectual context of the work, and increases knowledge in the field of research (Fink, 2013; Greenfield, 2002).

Literature Search

Various scholarly databases, books, dissertations, websites, and many other resources were searched to gather adequate background information to solidify my stance in conducting this research. The University of Manitoba online library system was used primarily to access electronic databases which were relevant to this study. Electronic databases including the Cumulative Index for Nursing and Allied Health (CINAHL) with full text, EBSCO host, Education Resources Information Center (ERIC), PubMed, and Scopus were searched. Other sources of information included Google Scholar and the University of Manitoba One Stop Search Engine. Search terms used included but were not limited to “intercultural communication”, “cross cultural communication”, “cultural competency”, “cultural diversity”, “cultural interaction”, “cultural safety”, “transcultural nursing”, and “undergraduate nursing” which yielded over 20,000 abstracts. Over 1000+ abstracts related to ICC were retrieved initially. Then, skimming was done to exclude some articles based on their titles, type of publication, and irrelevance. Inclusion criteria included research articles published in peer-

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reviewed journals within the last ten years, with an English rendition. However, due to the paucity of literature surrounding ICC, there was flexibility to include a handful of articles published before 2000. Only 52 empirical studies were related to ICC; 35 directly associated with ICC and 17 related to teaching and communication practices. Several research studies about transcultural nursing were also reviewed, to which 22 were used. This body of literature was purposefully and critically examined to elicit the required information necessary for this study (See **Appendix A** for details). Other relevant materials used were books and encyclopedia on ICC (Also see **Appendix A**).

Culture, Cultural Awareness, Cultural Sensitivity, Cultural Competence, Cultural Safety, Cultural Humility, and Cultural Responsiveness

Culture. Culture is sometimes defined as a way of life of people. From an essentialist point of view, it consists of patterns or traditions, beliefs, values, norms, and meanings that are shared in varying degrees by interacting members of a community, across generations (Barnett & Lee, 2002, p. 277; Racher & Annis, 2007; Ting-Toomey, 1999, p. 10). However, culture encompasses a variety of factors which may be visible or invisible. The Aboriginal Nurses Association of Canada (ANAC), Canadian Associations of Schools of Nursing (CASN) and the Canadian Nurses Association (CNA) contends that culture goes beyond beliefs, practices, and values (ANAC et al., 2009, p. 1). Often, only the visible aspects of culture such as race, food, clothing, color, and language are described or assessed when interacting with people from different cultures. Culture, like an iceberg analogy, was described by Hall in 1976. French and Bell (1979) highlight that some elements of culture remain hidden and there is a need to probe more to know since these hidden elements are essential. An iceberg has both visible (on the surface of the water) and invisible (below the surface of the water) sections (see **figure 1**).

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Some elements of culture mentioned previously can be seen easily at the upper part of the iceberg. However, those which are not obvious such as beliefs, why people do what they do, and values, form the most significant portion of the iceberg found beneath the water (Rothlauf, 2014, p. 26-7). Lack of awareness of the deep or invisible parts of peoples' culture often poses misunderstandings and influence ICC (Ian, Nakamura-Florez, & Lee, 2016; Jeong et al., 2011).

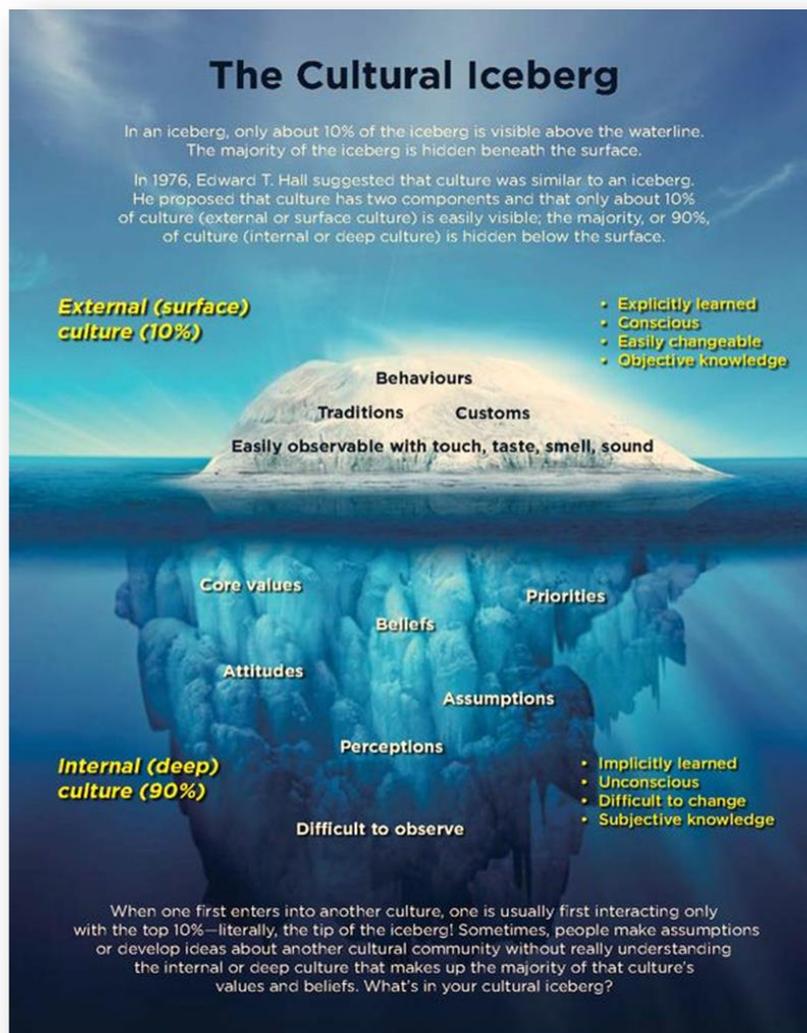


Figure 1. The Cultural Iceberg Model (Hall, 1976)

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Gray and Thomas assert that from a constructivist perspective, culture is a complex relational process which is receptive through an understanding of one's history, experiences, power relations, and gender (2006). This understanding can be reached ultimately through interactions with individuals, families, and communities from different cultures. Primarily, there is substantial evidence of differences in culturally defined communication behaviors. Culture shapes how individuals respond differently to some personal questions and physical contacts. Nurses need to be aware of the core differences between the various cultural groups to provide culturally safe care (University of Ottawa website, 2018). The University of Ottawa explains the various stages which can make one culturally responsive in providing culturally safe care to culturally diverse populations. These stages comprise cultural awareness, cultural sensitivity, cultural competence, cultural safety, cultural humility, and cultural responsiveness (University of Ottawa website, 2018).

Cultural awareness. Cultural awareness is the first step required to being culturally responsive. It involves observing and being conscious of similarities and contrasts between cultural groups to understand how culture may affect clients' approach to health, illness, and healing (University of Ottawa website, 2018). However, it first begins with knowing one's culture and then identifying how it shapes our values, beliefs, and practices as nurses. Campinha-Bacote defined cultural awareness as the process of conducting a self-examination of one's own biases toward other cultures and the in-depth exploration of one's cultural and professional background (Campinha-Bacote, 2007).

Cultural sensitivity. This term refers to being aware of, having understanding, and a deeper level of emotions that attach to your own culture and the way others will perceive your culture (University of Ottawa website, 2018). The University of Ottawa website further

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explains that cultural sensitivity influences our perception of culture, how others interpret our culture from their perspective, or how the differences in our culture impact our approach to people from different cultures. Some scholars state that it is imperative of the student nurse to have some cultural knowledge and be able to understand cultural practices related to verbal and nonverbal communication before and during ICC encounters (Campinha-Bacote, 2002; Fall et al., 2013). Solomon & Schell (2009) assert that individuals in some cultures avoid touch or physical contacts from the opposite sex. Likewise, in some cultures, people maintain eye contact during conversations, while others do not. Misinterpretation of these behaviors can lead to miscommunication (Osborne, 2005; Rothlauf, 2014, p.146).

Cultural beliefs related to illness affect how and when people will seek health care or adhere to medication or treatment regimes or biomedical health practices (Caron, 2006; Mobula et al., 2015; Nelson, Geiger & Mangione, 2002). Some individuals will follow traditional health practices before seeking the advice or assistance of health care professionals, as a last resort. They may also have their explanation of illness (Kleinman, Eisenberg, & Good, 1978; Kleinman & Pete, 2006; Rankin et al., 2005). An understanding of cultural influences on health care practices enables the nurse to effectively conduct assessments and individualize the care or teaching plan (McKeary & Newbold, 2010). The most efficient way of providing cultural knowledge is through education. Some authors propose adapting strategies like ‘asking the patient and family to define what they perceive as the cause of illness and what health practices the patient continues to follow’ to enhance the individualized planning of care for culturally diverse patients (Chang & Kelly, 2007; Rankin et al., 2005).

Cultural competence. It builds on sensitivity and refers to the attitudes, knowledge, and skills of practitioners necessary to become effective health care providers to patients from

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diverse backgrounds. Cultural competence is more than just being aware of differences; it refers to demonstrating attitudes and an approach that allows you to work effectively cross-culturally. It implies valuing and adapting to diversity; being aware of your own identity and cultural biases; and being able to manage the dynamics of treating different people (University of Ottawa website, 2018). Cultural competency has been identified as an essential component of health practice of which every HCP should be concerned (Okech et al., 2015). It is associated with improvement in the quality of health, as well as a reduction in racial disparities of health care (Provincial Health Services Authority [PHSA], 2013). Culturally diverse patients may present their symptoms differently, with different thresholds for seeking healthcare and may have limited English proficiency. It takes a culturally competent nurse (students or professionals) to interact effectively with such clients to assess and derive history for efficient health care delivery.

Calls for more culturally competent care have been on the rise, showing awareness of the need to educate professionals and help them reflect on their own and others' cultural attitudes, beliefs, behavior and communication strategies, and to modify practice skills that enable quality, non-discriminatory care (Guilfoyle, Kelly, & St. Pierre-Hansen, 2008; Pollock et al., 2012). The Canadian Nurses Association (CNA) refers to cultural competence in nursing as “the application of knowledge, skills, attitudes or personal attributes required by nurses to maximize respectful relationships with diverse populations of clients and co-workers” (2010). This definition implies that cultural competence requires core values such as acceptance, respect, equity, and commitment to a better relationship. It involves valuing differences in other cultures while delivering health services to them. It is therefore relevant to understand what culture is, its composition, as well as how to efficiently interact among cultures. Intercultural

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communication is key to providing a culturally safe and culturally competent health care delivery. For instance, the Canadian Association Schools of Nursing (CASN) endorsed cultural competency framework which was proposed by ANAC specifies the need for the graduating nursing student to demonstrate effective and culturally safe communication with First Nation, Inuit, and Metis clients, families, and peers (ANAC et al., 2009, p. 9).

Cultural safety. Cultural safety has its roots in nursing education (ANAC et al., 2009). Mkandawire-Valhmu & Doehring (2012) describes it as the power disparity between a patient and a nurse. Furthermore, it is referred to as the effective nursing practice of a person or family from another culture that is determined by that person or family (Nursing Council of New Zealand, 2011, p. 7). It first originated from an Indigenous nursing student in the New Zealand context. Ideally, the concept of cultural safety encompassed “an approach to healthcare that recognized the contemporary conditions of Aboriginal people which result from their post-contact history” (Brascoupe & Waters, 2009, p. 6-7).

Cultural safety has four principles which emphasize the need to enhance the well-being of Indigenous and Non-Indigenous New Zealanders, deliver healthcare through a safe workforce, acknowledge inequalities within healthcare, education and social interactions, and as well as understanding the power of health services and how health care impacts individuals and families. Although all the four principles advocate for cultural awareness and sensitivity in health care delivery, there has also been the call to equip nursing students with core competencies such as communication, inclusivity, respect, post-colonial understanding, Indigenous knowledge, and as well mentor and support them for success (ANAC et al., 2009). The ANAC et al’s ‘curriculum framework for First Nations, Inuit, and Metis nursing’ explains how facilitating curricula based on these core competencies can foster cultural competency.

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Cultural safety involves the nurse being self-reflective of the power differentials inherent in health service delivery, assuming the role of a health advocate, and being aware that the patient exists simultaneously within several cultural and health care systems which will interact with, and possibly conflict with, nursing interventions (University of Ottawa website, 2018).

Cultural humility. This term expresses cultural competency as an ongoing process, involving a life-long commitment to self-reflection, self-evaluation, and self-critique with regards to one's desire to learn and to maintain humility in our approach to patients (Chang, Simon, & Dong, 2012; Foster, 2009; University of Ottawa website, 2018). Cultural humility also implies a desire to fix power imbalances in a healthcare provider-patient encounter (University of Ottawa website, 2018). Other authors describe it as entailing the provision of care to individuals from different cultures without stereotyping or passing judgment but instead being open to accepting them, learning from them, and partnering in their health care delivery (Broome & McGuinness, 2007; Chang et al., 2012; Foster, 2009; Levi, 2009).

Cultural responsiveness: This refers to one rendering health care services that are respectful of, and relevant to the health beliefs, health practices, culture and linguistic needs of diverse patient populations and communities (State of Victoria, Department of Health, 2009). It situates the healthcare provider to render culture appropriate care void of stereotyping (University of Ottawa website, 2018).

Transcultural Nursing

Madeleine Leininger found transcultural nursing in the early 1950s when she identified some cultural differences between nurses and their patients while working with vulnerable children. She defined transcultural nursing as “ a substantive area of study and practice focused

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on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways” (Leininger, 1995, p. 58). In her quest to influence others to provide culturally congruent nursing care or culture-specific and universal nursing care, she developed the ‘theory of cultural care diversity and universality (CCDU),’ which contends that care and culture are interrelated within nursing. Leininger iterated that culture influences language, communication, family dynamics, diet, religious practices, birth and death rituals, and health care practices (Leininger, 1991). Leininger, therefore, recommended that nurses must consider how culture influences people’s experience of health, ill health and dying when planning and providing patient care (Leininger, 2008).

Leininger (2002b) iterates that the nurse needs to be “very knowledgeable about the client’s culture and diverse factors influencing . . . needs and lifeways” (p. 119). She proposes the holistic cultural assessment when caring for individuals, families, groups, and institutions to provide culturally congruent care (Leininger, 2002a; 2002b). The CCDU theory has three action modes for providing culturally congruent, holistic nursing care in health and well-being or when dealing with illness or dying namely: preservation and/or maintenance, accommodation and/or negotiation, and repatterning and/or restructuring (Leininger, 2006, p. 8).

Accommodation and/or negotiation, as well as repatterning and/ or restructuring, are essential in communication as one needs to interact with and adjust care practices and decision making to fit the culture of the individual, families, or groups (Sagar, 2012). However, Leininger does not highlight the process of ICC and how ICC skills are integrated into education or conversations. Moreover, Reid (2010) argues that Leininger’s cultural care theory has less semantic clarity as

compared to other cultural theories and models. For instance, the Leininger's CCDU/ Sunrise Model is comprehensive in content with the diversity of constructs with each concept within the diagrammatic model being defined. However, its recommended utilization was not well explained.

Other theorists have built on Leininger's work to develop other cultural care models (Campinha-Bacote, 2002; Narayanasamy, 2002; Papadopoulos, 2006; Purnell, 2002; Sagar 2012). However, none of them had a specific component on intercultural communication. This study required a model that could relate to the practical application of factors that contributed to ICC skills acquisition. Hence, the use of the IMICC model.

Communication and Intercultural Space

Communication. Dumessa and Godesso (2014) operationally defined communication as an understanding and interest to comprehend and learn the language, norms, values, and symbols of another way of life. Kourkouta & Papathanasiou (2014) also refers to it as a transaction and message creation whereby there is an exchange of information, thoughts, and feelings between a sender of the message and a receiver. They found that communication is always bidirectional and never unidirectional. This bidirectional implies that the message must be sent, decoded or interpreted by the receiver, and then a meaningful response is sent by to the initial sender of the message. Thus, there is a two-way interaction between the interlocutors.

Communication styles. There are different communication styles worldwide and this is evident in the verbal, non-verbal, and tone of interactions of people and their response to those interactions and this can be attributed mainly to cultural differences (Knapp, Hall, & Horgan, 2015). Hall (1983) considers this as low and high context cultures (see **figure 2**).

Communication can best be understood through its meaning, context, and code (Hall, 2000, p.36). Hall & Hall (1990, p.6) and Wurtz (2005) referred to the code as word utterances. By context, we refer to the situation, background, or environment connected to an event, a situation, or an individual. While people within the high context cultures tend to use indirect communication styles; non-verbal tactics and physical space to relay their intent, low context cultures are more direct, precise, open and truthfully express their intentions or feelings (Gudykunst et al., 1996; Hall, 1976, p. 79, 2000). Some of the indirect communication styles Hall found in face-to-face communication were gestures, body language, silence, and proximity to the other person. Also, Kim et al. found that most of the high context cultural communication depends on how close the interlocutors were to each other (1998, p. 512).

<i>High-Context</i>	<i>Low-Context</i>
China	Austria
Egypt	Canada
France	Denmark
Italy	England
Japan	Finland
Lebanon	Germany
Saudi Arabia	Norway
Spain	Switzerland
Syria	United States

Figure 2. High/Low Context by Culture (Hall & Hall, 1990)

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Lewis (2005) also proposed another cultural category of communication - linear active, reactive and multi-active cultures (p. 89, see **figure 3**). Linear active cultures were described as calm, factual, direct communicators, task-oriented, and good talkers and listeners at the same time. Meanwhile, reactive cultures were very good listeners, compromisers, accommodators, and slow to react to speech until a valid interpretation is made (p. 70-89). The third category, multi-active cultures, included people who were warm, impulsive, emotional, interruptive in discussions, and uncomfortable with silence.

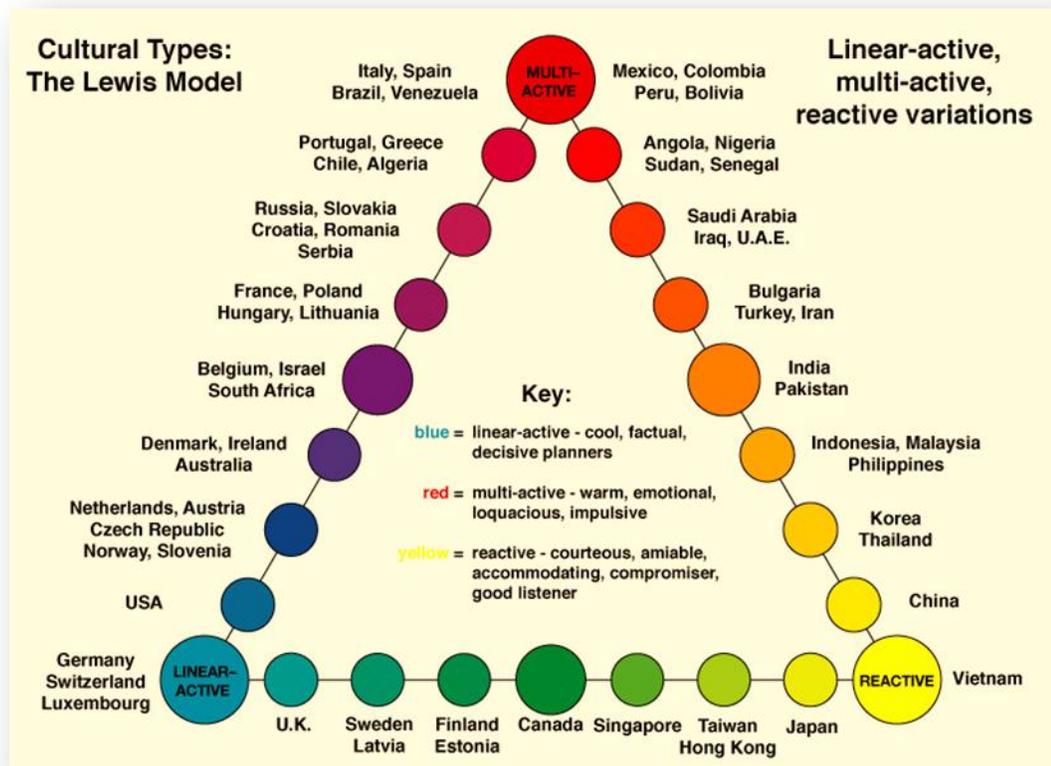


Figure 3. Cultural Categories of Communication (Lewis, 2005)

It is therefore essential to know the communication style of others in every interaction, through probing and observatory means, especially when the cultural backgrounds are different

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(Henderson, Barker, and Mak, 2016). This level of cultural awareness will prevent any form of misunderstanding and problematic communication (Ian, Nakamura-Florez, and Lee, 2016; Jeong et al., 2011).

Intercultural space. Intercultural spaces are defined by Arasaratnam (2012) as symbolic instances in which cultural differences affect communication in a unique or significant manner. These instances may include different thought communities (individual perceptions), cultural differences, and what is perceived as acceptable personal distance or space. The personal distance between communicators influences communication and such distances or spaces can be determined by cultural backgrounds (Beaulieu, 2004). These spaces could be the gap between seats, body orientation, or communicators standing face-to-face. Beaulieu (2004) found that Anglo Saxons used the largest zone of personal space, followed by Asians, then Caucasians, Mediterranean, and Latinos used the shortest distance. Latinos adopt a face-to-face position, while Caucasians tend to orient themselves to the side of the interlocutor. The non-verbal behaviors, like space, among people with cultural differences requires competence to interpret intent and meanings. Incorrect assumptions by one partner may pose a challenge in response to the other. Failure to understand intercultural space and lack of competence to deal with it may cause communication problems (Arasaratnam, 2012).

Intercultural Communication (ICC)

In the section below, ICC will be explained, and its associated challenges and facilitators will be highlighted. Likewise, the section will provide a brief history of ICC and details of its use in nursing education.

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Definition. Intercultural communication has been described as “communication among individuals who are agents of different cultures” (Matsumoto, 2010, p. x); the sending and receiving of messages across languages and cultures (Russel, 2009); “as communication that occurs where cultural differences between the relevant individuals affect the communication exchange in ways which would have been insignificant, had those differences not existed” (Arasaratnam, 2012, p. 136), among others. ICC education is a necessity to address the self-awareness, demographic, economic, technology, peace, and ethical imperatives of globalization and diversification (Maclean, 2015). However, there is limited literature on what ICC should entail in curricula.

Challenges with ICC. It is interesting to know that the way people of the same culture interact is vastly different from the interaction between people of different backgrounds (Qin, 2014). Arasaratnam (2012) posits that when people with similar cultural values and beliefs communicate with each other, they do so within the context of same assumptions unlike when people from different cultures communicate; their assumptions differ which can lead to misunderstandings. Moreover, ICC becomes more difficult when the language of communication is not the first language of all parties engaged in the conversation (Dumessa & Godesso, 2014). Dumessa & Godesso found that most students in higher level educational institutions experience communication barriers because of the multicultural and multilingual learning environment on their campuses. In other words, the cultural and linguistic backgrounds of other students are different from what they were familiar with. Consequently, intercultural miscommunication or misunderstandings occur when culturally diverse people have differing expectations, values, or experiences of social interactions (Dumessa & Godesso, 2014; Huang

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et al., 2012; Jonasson & Lauring, 2012; Qin, 2014). These miscommunications are seen usually in interactions involving high and low context cultures (Hall, 1976).

There have been “critical debates on issues of power, context, socio-economic relations, and historical or structural forces as constituting and shaping culture and intercultural communication encounters, relationships, and contexts” (Cameron, 2017; Halualani & Nakayama, 2010, p. 1). For instance, when a nurse interacts with a client, the client may view the nurse’s suggestions at the best fit for their health problems, and so it may affect client’s input in the planning of care. These may change how clients communicate or express their health beliefs while interacting with the nurse. Such instances expand on issues of power since the nurse is regarded as highly knowledgeable and has the authority to decide for the client. Historical context like the pre- and post-colonial experiences of Aboriginal people in residential schools has an impact on intergenerational trauma which may affect how they interact with health professionals (MacDonald and Steenbeek, 2015; Wilk, Maltby and Cooke, 2017). When people migrate due to socio-economic purposes, they find it difficult to adjust to the culture of the foreign land, and this may include access to healthcare as well as how they converse with HCPs since their perspectives are dominated by their own cultural beliefs (Luque & Oliver, 2005).

Carpenter-Song, Schwallie, and Longhofer (2007) expanded on culture from the constructivist perspective and expressed that culture is a relational process of shared meaning which may evolve depending on one’s social context and not merely accepted behaviors or beliefs. The views of these authors consider an individual in an evolving social context with an understanding that the person’s life and health are holistic (associated with many factors) instead of being the product of specific behaviors or beliefs. In effect, some cultures have

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gender dominance or hierarchical perspectives on decision making, as well as various explanations for illness, and actions towards wellness. Such views are likely to influence nurse-patient interactions and healthcare delivery (Giger & Davidhizar, 2002).

Ruppel and Brahm (2014) critically appraise ICC research and notes the gaps in problematic approaches to culture, the dominance of an interpersonal, microanalytic focus, and the agenda of ICC education. According to them, there is a need to critically look and assess the concept of ICC education in equipping learners of the needed skills and its impact on cultural interactions. I believe this is a valid argument to guide educators in considering ICC from a constructivist perspective rather than with an essentialist understanding. A study by Blanchet and Pepin (2015a) highlighted the fact that majority of strategies used to improve cultural competency have their basis on specific knowledge about given cultural groups (essentialism), which does not express the diversity within a given culture. According to them, culture evolves depending on historical, political, and social factors. These associative factors interrelate and may change over time; hence one practice routine cannot be adopted for a given culture. There must be a way to adjust practices overtime while incorporating diversity based on associative factors or individual experiences (constructivism). With the argument of Blanchet and Pepin (2015a) and Carpenter-Song et al. (2007), ICC must be understood and designed to incorporate diversity and not restrict learners to specific accepted behaviors or beliefs.

The need for ICC content/ facilitation. Researchers identify some negative impacts of ineffective ICC. Negative implications of miscommunication among HCPs and clients are dissatisfaction with care, lack of trust, anxieties and insecurity, doctor hopping, prejudice, adverse health outcomes, patient safety issues, and limited healthcare accessibility (Crawford, Candlin, & Roger, 2017; Gerlach et al., 2012; Hamilton & Woodward- Kron, 2010; Henderson

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et al., 2016; Jaeger, 2012; Kale & Syed, 2010). According to WHO (2019a), “every point in the process of care-giving contains a certain degree of inherent unsafety.” Patient safety issues are critical especially when the death of patients occurs due to miscommunications resulting from language and cultural barriers (Friedheim, 2016; Rice, 2014). Misunderstanding and miscommunication may occur when ambiguous terms are used in daily nurse-client interactions, and both parties fail to understand the verbal and non-verbal messages in the interaction due to cultural and linguistic differences (Hamilton & Woodward- Kron, 2010). Several authors like de Moissac and Bowen (2018), and Squires (2018) asserts that addressing language barriers in communication can prevent medication errors, improve patient assessment, diagnosis and planning of care; further leading to patient safety. ICC education is, therefore, needed to address the negative impacts of miscommunication among HCPs and client care delivery.

Oliveira (2013) asserts that being equipped with suitable tools and strategies for effective interaction with diverse cultures is vital especially in periods of crisis. Although some HCPs acknowledge the deficiency of such skills, they are apathetic in obtaining knowledge or training to enhance their practice (Fall et al., 2013; Oliveira, 2013). The basis for this inaction is rooted in a mono-cultured and ethnocentric worldview. It is therefore essential to introduce ICC at the formative educational level so that by the time of completion, graduate nurses will have the required skills to efficiently and effectively communicate with culturally diverse clients.

Ruppel and Brahm (2014) assert that an in-depth understanding of the distinct and defining constituents of an intercultural encounter as well as the appropriate strategies for integrating ICC skills in educational programs are the only mechanisms to close the gap in ICC. Social inequities exist wherever there are issues related to ineffective ICC, and this can only be

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addressed through education (Blanchet et al., 2018; Krieger, 2014; Solar & Irwin, 2010). An individual's race speaks volume of their culture and is also a critical determinant of health; however, some ethnically diverse client undergo discrimination, experience derogatory comments and reactions in their interaction with healthcare providers (Krieger, 2014; Varcoe et al., 2013; Solar & Irwin, 2010). Such disrespectful and problematic interactions lead to health inequalities and social injustices. Chinn (2014), Hardy (2011), and Thorne (2014) indicated in their studies that the integration of principles of social justice, which includes cultural education, in nursing curricula could help address this crucial issue. Fortunately, several studies have been done on how to incorporate culture in educational programs (Sairanen et al., 2013). However, there is no literature on how to integrate ICC specifically in nursing education programs to breach the problematic cultural communications that lead to social injustices.

History of ICC facilitation. ICC facilitation gained roots in the 19th century when the population of the United States (US) became more culturally diverse. There were a series of research conducted around ICC at the time. According to Ruppel and Brahm (2014), Oberg's (1960) "discovery" of the phenomenon of culture shock propelled the need for ICC educational programs among the US populace. The 1974 formation of the Society for Intercultural Training and Research (SITAR; today SIETAR to include education) institutionalized this development and furthered the popularity of ICC facilitation.

ICC education in nursing. There have been various approaches to integrate intercultural knowledge in health education programs such as nursing. Academic interventions to promote cultural competency, cultural safety, and ICC include the use of theoretical frameworks, cultural diversity courses, courses about the history of Canada and First Nations, Metis, and Inuit peoples, experiential learning activities, technological, and international

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experiences (Burke, Chaney, & Kirsten, 2010; Crawford et al., 2017; Harder, 2018; Henderson et al., 2016; Majda, Zalewska-Puchała, Bodys-Cupak, & Kamińska, 2015; Parent, 2007; Wros & Archer, 2010). Intercultural education generally sensitizes and enhances the understanding of diverse persons from different cultures and places (Cargile, Mao, & Young, 2019; Chan, Fung, Tsang, & Yuen, 2018). Campinha-Bacote (2002) posits that cultural awareness facilitates cultural knowledge, which in turn builds the desire to have an encounter with people from different cultures. This process, when practiced continually, builds one's confidence and enhances cultural competency.

Cultural diversity courses which inhabit cultural communication or interaction contents are delivered in many ways. It equips students with the needed cultural knowledge, skills and attitudes to enable them to interact with others in a respectful, empathetic, and acceptable manner. Cultural diversity education may include teachings that accept and respect the normality of diversity through all lifespan and cultural contexts (Cargile et al., 2019; Chan et al., 2018).

Some schools have adopted linguistic and cultural competency frameworks in their curriculum to guide nursing practice (ANAC et al., 2009; Crawford et al., 2017). Meanwhile, Henderson et al. report the introduction of cultural diversity content to nursing curricula and the use of cultural validation techniques to equip nursing students with ICC and cultural competence skills (2016). Other nursing programs have sent undergraduate nursing students to different countries or used video conferencing technology to gain exposure to other cultures and how people behave and interact within the healthcare system in other parts of the world (Burke et al., 2010; Wros & Acher, 2010).

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Madja et al. (2015) also provide further examples of how kinesthetic and sensory learning styles have been used to facilitate easy understanding of intercultural concepts. It is evident that limited strategies have been incorporated to address the ICC in nursing education specifically.

Learning styles. Students have different learning styles in terms of how they perceive, process, and adapt information. Employing active, student-centered teaching strategies, as opposed to the traditional methods of lecturing, will promote learning and retention of information (Tanner, 2009). Evidence shows that some students dominate specific learning styles; auditory, kinesthetic, visual, and tactile (Beischel, 2013; Fleming, McKee, & Huntley-Moore, 2011; Hallin, Häggström, Bäckström, & Kristiansen, 2016). Beischel (2013) reports that auditory learners prefer hearing verbal instructions while visual learners like reading literature and observing pictures, flashcards and videos. Tactile learners prefer hands-on-activities while kinesthetic learners prefer the learning-by-doing approach and learn best through experiential learning sessions, case studies or computer simulation.

Teaching media and strategies. Ying and Ying (2012) proposed that teachers should assist students to develop appropriate cultural attitudes and improve their ICC competence to meet the demand of the globalized world. According to them, there are diverse means by which students receive information on ICC: websites, textbooks, and in-class. However, I was unable to locate research exploring student perceptions as to which media serves the best purpose.

Teaching strategies, when carefully structured, can engage students in an active learning process. It is important for nurse educators to select appropriate teaching strategies to deliver high-quality education. According to literature, nursing education which includes intercultural

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education is offered in several modes which include didactic (in-class and online delivery), simulations, and clinical rotations. However, there have been occasional debates on how content is to be taught to address the learning needs of students (Forbes & Hickey, 2009). It will be essential to know the best ways in which ICC may be facilitated; either through didactic, simulation, or clinical, and its potential influence on student learning.

Didactic. Didactic session of education includes but is not limited to lectures, concept mapping, and case studies, most have a basis in social learning or the constructivist theory. The social learning theory proposed by Bandura (1977) and Lev Vygotsky (1978) indicates that learning occurs in a social context with an active integration of the learner in a community of practice through coaching (Torre, Daley, Sebastian, & Elnichi, 2006). Bandura stressed on learning occurring through motivation, observation, modeling of behavior and attitudes and influence of emotional reactions of others. In this view, learning involves the collaborative efforts of instructors, learners, peers, and the environment. The use of interactive lectures, either in-class or online, with the introductory of problem-solving scenarios can equip students who are auditory and visual learners. The use of active teaching strategies enables students to engage in activities of learning, retain more information for understanding, think critically, apply knowledge acquired in creative ways, and facilitate teamwork (Eison, 2010).

Simulation. High fidelity simulations are increasingly becoming a better medium to transfer theoretical knowledge into practice (Nagle, McHale, Alexander, & French, 2009). Simulation was defined by Gaba (2007), as an educational strategy in which a particular set of conditions are created or replicated to resemble authentic situations that are possible in real life. High fidelity simulation was introduced worldwide in 1915; however, it was adopted in Canada after the year 2000 (Garrett, MacPhee, & Jackson, 2011). Simulation experience can improve

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the skills of students before attending to real clients (Garrido, Dlugasch, & Graber, 2014). It originates from a social constructivist theoretical base (Wiggins, 2012) with a segment of it radiating from a critical perspective focusing on culture care and patterns.

Nursing students engage in experiential learning which includes role play, case scenarios, and problem-based learning, to mention a few. In other words, they are exposed to similar situations that mimic the patient's problems and environment, thereby enabling them to apply theoretical knowledge into practice. On the other hand, nursing students are usually given patient situations or scenarios to stimulate them to acquire and use prior knowledge to solve problems (Durham & Alden, 2008). Role play is also a teaching method that explores clinical case scenarios. This teaching method facilitates the use of critical thinking, clinical reasoning, communication skills, and psychomotor skills. Such problem-based learning methods are also used to appraise the ICC skills when scenarios are presented with cultural diversity content. These real patient scenarios provide fora for students to respond to how best they can interact with culturally diverse clients during their practicum while delivering holistic care.

Clinical education. Clinical education refers to regular successive and current postings of various groups of nursing students belonging to different classes in specific nursing fields. i.e., outpatient departments (OPDs), specialty wards, occupational therapy (OT), delivery room, clinical, community health fields-Clinics outreach center, sub-center, health center, schools.

In addition to the above, ICC occurs in diverse contexts or disciplines (Hu & Fan, 2010). Since health care is delivered by multi-disciplinary teams, of which the nurse is part, there has been an additional need to teach ICC to undergraduate nursing students. A challenge to the above is the lack of resources or specific strategies to address ICC globally and the desire

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to use neo-colonial constructs of a white western monoculture to shape ICC in healthcare delivery (Cargile & Bolkan, 2012; Grant & Luxford, 2011). Meanwhile, Gerlach and his team recommended that ICC must be conducted based on the variability of individuals and not on the construction of "rules" for the appropriate behavior in contact with people from "different cultures" (2012). Their statement expresses the uniqueness of individuals and the need to interact and care for people while focusing on both their needs and background.

Some nursing students practice therapeutic communication skills to disseminate their theoretically acquired western bio-medical model of explanation of diseases, nursing interventions, among other actions. Such interactions bring dissatisfaction to clients as they feel that they are not heard, or their views are not respected. In this view, Kale and Syed (2010) suggest that cultural training for HCPs should focus on various ways of raising awareness regarding the legal and ethical responsibility of HCPs to ensure that they maintain sufficient levels of communication with their clients.

Barriers to ICC encounters. Some obstacles to ICC encounters include lack of cultural awareness, prejudice, stereotyping cultural behaviors, difficulty understanding English, discrimination, time constraint for education and nurse-patient interactions, and inadequate curriculum component (Henderson et al., 2016; McKeary & Newbold, 2010; Philip et al., 2015). Some of the barriers mentioned above are individualistic and attitudinal; while others may be due to contextual factors in health or academic institutions. Various authors assert that the lack of personal interest in others' cultural backgrounds, having a mono-cultural viewpoint, and failure to explore or use accepted ICC strategies and tools can be a hindrance to effective ICC (Oliveira, 2013; Stadler, 2013).

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Enablers of ICC encounters. Recommendations regarding factors that facilitate effective ICC are both attitudinal and contextual (Fall et al., 2013). This recommendation implies that both individuals and academic programs must work efficiently to address issues with problematic ICC. The facilitators of ICC may include but is not limited to integrating diversity into curricula, frequent conscious-raising practicums/ field placements, cultural knowledge, cultural skills, cultural desire, and personal reflection (Jonasson & Luring, 2012; Liddicoat, 2009; Oliveira, 2013; Stadler, 2013; The American College of Obstetricians and Gynecologists, 2011).

The academic faculty is encouraged to vary their teaching strategies to engage students in an active learning process (Tanner, 2009). If active teaching and learning strategies like case studies, concept mapping, role play, lectures, simulation, and clinical placements are employed effectively, nursing students are more likely to process and adapt the information associated with the lesson (Garrido et al., 2014; Nagle et al., 2009; Wiggins, 2012). It is important for nurse educators to select appropriate teaching strategies in areas of ICC facilitation to enable nurses to respond adequately and humanly to patients' needs and expectations (Kourkouta & Papathanasiou, 2014).

Gap identified. There is limited literature on ICC in nursing education; frameworks/ models, content, teaching pedagogy and methods, experiences, exemplars, impact, to mention a few. ICC strategies, models, practical use/ exemplars, and evaluation could facilitate a better adaptation of ICC in everyday life; especially in the life of a student nurse. This study explored the perspectives of undergraduate nursing students regarding ICC in their nursing program.

Conceptual Framework

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The Integrated Model of Intercultural Communication Competence (IMICC) by Arasaratnam and Doerfel (2005) guided this study. IMICC was developed using an emic approach that incorporated multi-cultural perspectives from over 400 people from 15 different cultural backgrounds. It was further tested in 2010 using the structural empirical model and has been cited by over 30 researchers in different disciplines (Arasaratnam, Banerjee, & Dembek, 2010). This report shows that the model is transferable in various contexts and groups. Therefore, it was deemed as an appropriate guide for this study. It articulates that key variables such as experience/ training, global attitude, motivation, involvement/ interaction, and empathy contribute to ICC competence irrespective of visible cultural differences (See **Appendix B**).

Inter-conceptual relationship. From the figure in Appendix B, it is evident that motivation and interaction involvement have direct impacts on ICC. Motivation is also influenced by global attitude. Likewise, empathy influences interaction involvement and positive global attitude. Global attitude and motivation have a direct impact on interaction involvement. According to the inter-conceptual relationships, experience, and training in ICC influences positive global attitude, which in turn spikes the motivation to interact with people from other cultures, leading to more ICC encounters, experience, and competencies. Experience and education are the focus of the study exploring nursing students' perspectives of ICC. From the responses gathered from participants, I was able to conclude if experience and training (hereafter, referred to as education) were perceived to have an impact on the ICC skills of student nurses; their level of cultural awareness, students' competencies in their approach to culturally diverse clients, and or perceived improvement in nurse-patient relationship.

Key variables/ concepts of IMICC and their psychometric properties. There are five key concepts in the IMICC framework; motivation, empathy, experience/ training, interaction

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involvement, and global attitude. All five concepts lead to ICC competence. Although this model was derived using an emic approach, it was tested initially with the structural equating modeling, and in 2010, it was further tested with a multi-item scale using a Confirmatory factor analyses (CFA) to ensure that it met the criteria of face validity, internal consistency, and parallelism. Reliability was estimated by using Cronbach's alpha. The key concepts are described below as was outlined in Arasaratnam et al. (2010).

Motivation can be explained as a set of feelings, intentions, needs, and drives associated with the anticipation of or actual engagement in intercultural communication (Wiseman, 2002, p.211, as cited in Arasaratnam et al., 2010). A sample question included "How do you enjoy initiating a conversation with someone from a different culture?" Its psychometric properties were Cronbach's alpha=.78, M= 5.38, and SD= 1.18. The Cronbach's alpha for motivation shows that the internal consistency of the scale items related to motivation is acceptable since it reliably measured its intended purpose. The scale had responses ranging from (1) Strongly Disagree to (7) Strongly Agree; hence a mean score of 5.38 is a very good average score and demonstrate how participants will enjoy interacting with culturally diverse groups.

Empathy is one's ability to be an active listener, to pay attention, to be aware, and consider the situation from the other person's perspective and feelings and react accordingly. Arasaratnam et al. (2010) defines it as the capacity to clearly project an interest in others, as well as to obtain and to reflect a reasonably complete and accurate sense of another's thoughts, feelings, and or experiences. A sample question included "How do you take other people's habit into consideration?" Its psychometric properties were Cronbach's alpha=.85, M= 5.14, and SD= .81. Using the Rule of Thumb, it is evident that the Cronbach's alpha for empathy shows that the internal consistency of the scale items related to empathy is good since it reliably

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measured its intended purpose. The scale had responses ranging from (1) Strongly Disagree to (7) Strongly Agree; hence a mean of 5.14 is a very good average score and indicate that participants may empathize more with people from culturally diverse clients.

Interaction involvement can also be referred to as engaging in active listening by paying close attention to the other person's communication. A sample question included "During interaction with someone from a different culture, how do you listen carefully and obtain as much information as you can?" Its psychometric properties were Cronbach's $\alpha=.71$, $M=4.61$, and $SD=.89$. The psychometric properties stated above means that the Cronbach's α for interaction involvement reveals that the internal consistency of the scale items related to the concept is acceptable since it reliably measured its intended purpose. The scale had responses ranging from (1) Strongly Disagree to (7) Strongly Agree; hence a mean of 4.61 is a good/ an acceptable average score. The standard deviation is also minimal.

Experience or education was measured based on whether a participant had studied abroad, lived abroad for more than three months, had formal education in intercultural communication, and had close personal friends from other cultures. Questions were related to their travel history, studies abroad, or the number of cultures experienced. Its psychometric properties were $M=2.41$, and $SD=1.18$. This concept had no reliability coefficient making it difficult to determine the internal consistency of scale items to measure its intended purpose. Moreover, the scale had responses ranging from (1) Strongly Disagree to (7) Strongly Agree; hence a mean score of 2.41 is below the average which is not acceptable. It seems experience or education has minimal influence on the process leading to intercultural communication competency as opposed to empathy.

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Lastly, global attitude was referred to as a positive, non-ethnocentric attitude towards people who are culturally different from one's self. A sample question included "Do you believe people from other cultures should be treated the same way as those from your culture?" Its psychometric properties were Cronbach's $\alpha=.65$, $M= 5.13$, and $SD= .74$. Applying the Rule of Thumb, it is evident that the Cronbach's α for global attitude shows that the internal consistency of the scale items related to global attitude is questionable since it partially measured its intended purpose. The scale had responses ranging from (1) Strongly Disagree to (7) Strongly Agree; hence a mean of 5.13 is a very good average score.

Intercultural communication competence also had Cronbach's $\alpha=.70$, $M= 4.82$, and $SD= .76$. Sample question included "Do you usually change the way you communicate depending on who you are communicating with?" The Cronbach's α for intercultural communication competence shows that the internal consistency of the scale items related to the concept is acceptable since it reliably measured its intended purpose. A value of .70 also implies that it is internally consistent. Moreover, it also implies that there is an increase in inter-correlation among the test scale items. The scale had responses ranging from (1) Strongly Disagree to (7) Strongly Agree; hence a mean of 4.82 is above the average which is good. The standard deviation is also minimal (less than 1) which shows how close the test scale items are to one another. Conclusively, the model can, therefore, be used by other researchers for their study.

Chapter Summary

In this chapter, a review of literature facilitated a backdrop for the need to explore nursing students' perspectives of ICC. Key concepts were defined and explained such as

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culture, cultural awareness, cultural sensitivity, cultural competency, cultural safety, cultural humility, cultural responsiveness, transcultural nursing, communication, and intercultural space. Eight themes emerged from the review of ICC from 44 sources: definition of ICC, challenges of ICC, the need for ICC content/ facilitation, history of ICC, ICC education in nursing, approach to ICC facilitation, barriers and enablers of ICC encounters, and identified gaps from literature. It was recognized that to attain cultural safety and cultural competency, patient safety, and effective communication, there is a need to embed cultural knowledge including ICC, in nursing education programs. These can be introduced using various pedagogies and teaching strategies that will suit the undergraduate students' context. The paucity of literature on exemplars or approaches being used to teach ICC and evaluation of the impacts of ICC education on students is a gap that was identified. The researcher surmises that this qualitative descriptive study will help address the shortfalls.

Chapter Three: Methodology

This chapter provides a detailed description of the research design, methods, and the philosophical justification for using a qualitative descriptive design for this study. This chapter also highlights the sampling technique, setting, sources of data, data collection procedures, data analysis plan, methodological rigor, and dissemination plan.

Study Design

This study used a qualitative descriptive design guided by the Integrated Model of Intercultural Communication Competency (IMICC) framework (Arasaratnam & Doerdorff, 2005). Qualitative descriptive is one of the approaches in qualitative research methodology. It is fairly interpretative in nature, and the researcher presents the realities of participants in their subjectivity. In other words, the researcher offers a comprehensive summary in simple terminologies or language as presented in the event or by the participant. It describes data as derived from its natural setting. Sandelowski reports that descriptive and interpretative validity is implicitly necessary to determine the accuracy of data reporting (2000, p. 336). Thus, descriptive qualitative designs ensure that the researcher stays closer to the data as much as possible (Neergaard, Olesen, Andersen, & Sondergaard, 2009, p. 2; Sandelowski, 2010, p.78). Qualitative descriptive designs usually require an eclectic foundation and consideration in terms of sampling, data collection, analysis, and reporting findings (Magilvy & Thomas, 2009, p. 299).

Qualitative descriptive research is the least theoretical among qualitative designs (Sandelowski, 2000, p.337). It may or may not be conducted based on a theoretical framework (Miles, Huberman, & Saldana, 2014; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016, p. 1194).

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According to Neergaard et al., it also has some overtones in the works of other qualitative designs which may influence its philosophical underpinnings (2009, p. 2-3). Philosophical assumption and structures are vital in the determination of the appropriateness of the methodological process for qualitative research. It may also guide the researchers in data analysis and presentation of findings. Neegaard et al. (2009) report that qualitative descriptive studies usually occur in nursing and medical research because of its relevance in obtaining firsthand knowledge of patients, relatives or professionals with a topic of interest- in the context of this study, ICC. According to Magilvy and Thomas, findings from a qualitative descriptive study can also provide in-depth knowledge of a clinical situation as well as the information needed to develop new interventions (2009, p. 300). Scotland contends that knowledge discovery is subjective (2012, p. 9). Therefore, individuals participating in such social experiences are the best people to describe their experiences (Cohen, Manion, & Morrison, 2007, p 19).

Based on the perspective shared above, and since ICC is a strategy for addressing health inequities, the critical social theory will be the philosophical underpinning for this research design. It is vital for nurses to critique the idea of social injustice and health disparities related to nursing care, to be able to take actions against issues that will render their work inefficient. This process can commence during their educational process where there will be platforms for reflective journals of constructs of curricula and evidence-based information that influences undergraduate nursing students' growth and future practices (Kirkham, Baumbusch, Schultz, & Anderson, 2007; Munhall, 2012). Undergraduate nursing students will then acquire skills to critique predefined tools and meanings of ICC that instructors have taught them before commencing their professional nursing practice. Both qualitative descriptive studies and critical

social theory are rooted in a constructivist world view which emphasizes active involvement of students in education.

Sampling Technique

Creswell and Plano (2011), Elo et al. (2014), and Patton (1990, 2002, 2015) recommend that the participant is knowledgeable about the phenomenon of interest so that rich data can be elicited in situations of lower participation. According to Morse and Niehaus (2009), the sampling technique should be able to maximize the efficiency and validity of the data collection. The most commonly used method in content analysis studies is purposive sampling (Kyngäs et al., 2011; Onwuegbuzie & Leech, 2007); hence, maximum variation sampling, a type of purposive sampling technique would be used to recruit participants.

Maximum variation sampling was used because it can capture and describe central themes that cut across a lot of participants or program variation (Creswell, 2002; Patton, 1990; Sandelowski, 2000). Patton further explains that “for small samples, a great deal of heterogeneity can be a problem because individual cases are so different from each other. However, this sampling strategy turns that apparent weakness into a strength by applying the following logic: Any common patterns that emerge from great variation are of interest and value in capturing the core experiences and central, shared aspects or impacts of a program” (1990, p. 172). Although the sample is comprised nursing students, the researcher assumes that they are from diverse cultural backgrounds and engaged in different simulation sessions with varying contents of ICC. Moreover, they were taught by different instructors depending on their cohort (although the same curriculum, two cohorts per academic year), had clinical placements in different health facilities, and encountered different culturally diverse clients at varied times.

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The diversity of experiences with ICC training among this sample size may enrich the study with high-quality, detailed descriptions of the variation in the group, and help the researcher to understand differences in experiences while also investigating core elements and shared outcomes of the nursing program variations.

The target population (4th-year undergraduate nursing students) was estimated at 100. However, selecting the most appropriate sample size is essential for ensuring the credibility of content analysis study (Graneheim & Lundman, 2004). Guthrie, Yongvanich, and Ricceri (2004) and Sandelowski (2001) assert that data saturation may indicate the optimal sample size. Although no published literature has specified the sample size for the qualitative descriptive study, Cohen and Crabtree (2008) recommend that the researcher selects a small number of units that maximize the diversity relevant to the research question. The researcher assumed that a sample of 15 fourth year undergraduate students would be able to provide data saturation as well as the rich, in-depth perspectives of students at various points in the program regarding ICC. However, only 10 participants volunteered to participate in the study by a specific date. I found that data saturation occurred with 10 participants.

Creswell (2013) recommends that when using purposeful sampling, the researcher must decide the inclusion criteria for the sample, as well as how many people or sites need to be sampled. For this study, the eligibility criteria required participants to: i) self-identify as an undergraduate nursing student in College of Nursing in the University of Manitoba ii) complete a cultural diversity/ communication course and engage in clinical rotation, iii) be willing to participate in 45-60 minutes, audio-recorded, one- on- one interview. These inclusion criteria ensured that only persons with the needed knowledge and experience with ICC participated.

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Setting

This study was conducted in Canada, specifically, the province of Manitoba. It is necessary to recruit individuals who have been exposed to various teaching strategies regarding the concept and have experienced such interactions during their clinical placement to obtain accurate information about ICC in nursing education. In this case, undergraduate nursing students from the University of Manitoba, College of Nursing (CoN) were recruited to participate in this study. The institution is located within Winnipeg; on the Fort Garry campus within the Helen Glass Centre for Nursing building. The CoN offers a four-year Bachelor of Nursing program with students who undergo didactic, simulation, and clinical placements in the hospitals, long-term care, and community settings to be adequately prepared to the nursing profession. A private location amenable to the participants was arranged for the interviews.

Measurement/ Data Sources

Three sources of data were used for this study; interviews, reflective memos/journals, and participants demographic data. At the start of each interview, informed consent was sought after which participants were requested to respond to a short demographic questionnaire. The demographic data were used to describe the participants' characteristics which may be relevant to the topic under study. Demographic data included: year of study, gender, age, travel history, and country of origin.

A semi-structured interview guide (see **Appendix E**) was used to elicit data from participants. The questions were open-ended and framed to reflect the concepts of the IMICC framework. The researcher was cautious in reacting to answers to the research questions so that she will not steer the participants' response which may lead to obtaining deductive data. It is

essential that the participant responds without coercion or the influence of the researcher's assumptions. This caution step will enable the researcher to obtain an inductive data (Elo et al., 2014, p. 4). This measure was implemented to enhance credibility at the data collection stage. Participants' responses determined if other questions should be added, eliminated, or altered to provide in-depth information on the topic of interest. Since interviews were the primary data, analysis began with the first interview. Also, the researcher looked for commonalities and differences in participants' experiences within and across the data and added to the questions as and when necessary (Sullivan-Bolyai, Knafl, Deatrck, & Grey, 2003).

A reflective journal was kept immediately following each interview and during the data analysis phase (see **Appendix E**). The reflective journal contained the researcher's thoughts, observations, and feelings before, during, and after each interview. It provided a venue to document identified biases, differences, attitudes, and values of the researcher, as well as all observations made during the interviews. Willis et al. postulate that the reflective memo will improve the transparency of analytic insights and speculations (2016, p. 1196). This reflective journal was included in the documents for data analysis.

Recruitment and Data Collection Procedure

Permission to access undergraduate nursing students was requested from the College of Nursing Leadership Team via the Manitoba Centre for Nursing and Health Research (MCNHR) (See **Appendix C**). Ethics approval was then sought through the University of Manitoba Education/ Nursing Research Board (ENREB). Following approval by ENREB, a recruitment e-mail invitation (see Appendix C) was sent to all potential study participants via blind copy on behalf of the researcher by James Plohman, Research Coordinator of the MCNHR. A copy of

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the consent form (see **Appendix D**) was attached to the recruitment email. The initial response rate at week one was discouraging (three participants); hence another recruitment email was sent weekly within the next three weeks. Only participants who met the inclusion criteria could participate in the study.

Interested participants were requested to contact the researcher. The researcher contacted the participants by e-mail, provided further information about the study, and arranged for a mutually convenient date and time for the interview. A hard copy of the informed consent form was provided when the researcher met each participant in person. One copy was given to the participant to be kept for record purposes. The researcher kept the other signed copy in a locked filing cabinet, separate from all other study material.

A semi-structured interview guide was used to conduct a face-to-face interview (see Appendix E) (Sandelowski, 2000, p. 338). Each interview began with establishing rapport with the participant; after a signed informed consent, the participant was invited to respond to a short demographic questionnaire. Immediately following the interview, the researcher documented a reflective memo of the proceedings.

Following the interview, each participant received a \$25 gift card from the University of Manitoba bookstore. A summary of preliminary findings (include in the appendices) was emailed to participants so that they could verify, substantiate, or refute the study's findings. Upon completion of the study, participants were provided an executive summary of the study's findings.

Ethical Consideration

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The Tri-Council Policy Statement (TCPS 2, 2014) guided the ethical considerations for the study. The Tri-Council consist of the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences of Humanities Research Council of Canada. The provincial legislation known as the Personal Health Information Act (PHIA) will also be used to guide the researcher.

Ethical consideration is vital in this study because data collection was done with human participants. Human participation in the study implied that all statements in the TCPS 2 (2014) on ethical conducts in conducting research involving human must be adhered to. Article 1.1 of the TCPS 2 (2014, p. 6) recommends ensuring respect for human dignity. Strategies such as seeking permission to voluntarily engage in the research study from the academic institution and the participants were taken to ensure that everyone provided consent prior to participation. Participants were also given the free will to opt out of the study at any time. On no occasion was a participant coerced into engaging in the research or providing responses that affected them emotionally or psychologically. This action was taken to ensure that no harm was done to the participant (Polit & Beck, 2012). However, a low level of emotional distress was anticipated, on the part of participants, for this study.

During the data analysis, all identifiable cues were taken off the transcript, consent forms and data collected were stored on a shared drive with a password known to only the researcher. This action ensured that anonymity was met.

Data Analysis Plan

According to Creswell (2007), a researcher's choice of data analysis technique will determine the richness or content of information on the phenomena being studied. In this view,

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the digitally recorded interviews were transcribed verbatim, read and re-read by the researcher and her advisor to determine emergent ideas or nodes. Transcripts were further inputted into NVivo version 12 Pro, a qualitative data management software, for retrieval and in-depth analysis. The reflective journal kept by the researcher was also imported into the NVivo software and compared with the transcribed data to ensure data consistency, reflective of what was retrieved from participants as well as eliminate any biases.

For this study, qualitative content analysis was used explicitly for the data analysis (Miles et al., 2014; Sandelowski, 2010; Schreier, 2012) to facilitate the analysis of sensitive nursing concepts, and as well offer a simple format for reporting common issues mentioned in the data (Elo & Kyngäs, 2008; Gbrich, 2007; Green & Thorogood, 2004; Schreier, 2012; Vaimoradi et al., 2011). In other words, the use of content analysis facilitates the detection of key content areas of the data and integrates those content areas into consistent results (Willis et al., 2016, p. 1196).

Vaimoradi et al. (2013, p. 399) and Sandelowski (2000, p. 338) contends that content analysis is suitable for research studies with a relatively low level of interpretation. This inference implies that the qualitative descriptive design used for this study can employ such analytic techniques as it involves a minimal interpretation of data (Sandelowski, 2000). Content analysis is largely based on the “factist” perspective. A factist perspective assumes data to be accurate and truthful indexes of the reality out there (Sandelowski, 2010). It facilitates the analysis of data that answers questions like ‘what are’ (Ayres, 2007). Gbrich (2007) and Sandelowski (2000) contends that qualitative content analysis can analyze verbal and visual data to provide a summarized informational content of that data.

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Qualitative research is generally characterized by the simultaneous collection and analysis of data whereby both mutually shape each other (Sandelowski, 2000, p. 338). Therefore, an analysis of data commenced with the first transcript to allow room for the researcher to modify codes and sub-codes as well as generate new ideas for subsequent interviews. During the analysis of transcripts with the Advisor, the researcher applied pre-existing codes to the data. These codes were derived from the original data and not per the researcher's assumptions. This step was taken concurrently with analysis of reflexive journals to ensure codes reflected participants' voices.

For this study, an inductive approach was employed for the qualitative content analysis because no studies have been done specifically to elicit the perceptions of nursing students concerning ICC and therefore the coded categories were derived directly from the interview transcripts (Hsieh & Shannon, 2005). This involved three phases; preparation (collecting suitable data for content analysis, making sense of the data, and selecting the unit of analysis), organization (open coding, creating categories, and abstraction), and reporting of reports (presented as a description of the content of the categories) (Elo & Kyngäs, 2008; Elo et al., 2014, p. 1-2).

At the preparation stage, the researcher became immersed in the transcribed data by reading and rereading the transcripts and reflective memos carefully. The data was analyzed systematically under each interview theme, building on the IMICC framework which guided the interview questionnaire. This analysis enabled the researcher to make sense of the whole data. Following this, the researcher decided whether to develop categories from the data (manifest content) or develop themes (latent content) before proceeding to the next phase of

data analysis. Categories were developed under the heading ‘nodes’ in the qualitative software being used for the analysis.

The organization phase began with the researcher manually extracting data from each transcript and reflective memo which reflected an original node and placing the codes under their potential categories. The next step was to compare the emerging coding’s clusters together and with the entire data set. The researcher then reported the actions carried out in the previous phases under themes. This report may be presented as a map, model, or storyline. For this study, the researcher used a map. The researcher ensured that this map was detailed and reflective of the process in acquiring the content of the categories. Below is a map of the data analysis process.

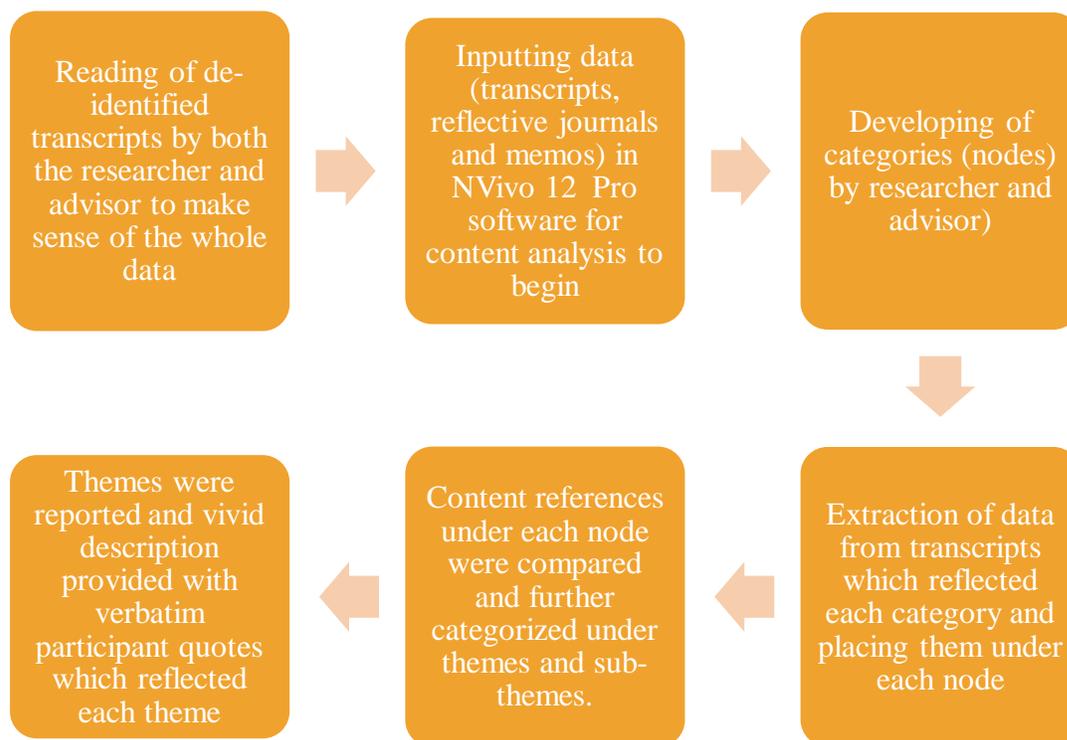


Figure 4. Summary of data analysis process

Methodological rigor and trustworthiness. Kyngäs et al. (2011) posit that qualitative descriptive studies imply that researchers use qualitative criteria when evaluating aspects of validity in content analysis. In this case, the most appropriate word, according to Lincoln and Guba (1985), is trustworthiness, which implies that it is “worth paying attention to” the findings of the research. Trustworthiness was assessed throughout data collection, analysis, and the presentation of the findings. The evaluative criteria would include its credibility, dependability, confirmability, and transferability, and authenticity (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Polit & Beck, 2012).

Credibility. This term is the concept used in qualitative research to express how the internal validity of the study is maintained. Credibility, according to Merriam (1998), must be able to answer the question, “How congruent are the findings with reality?” The researcher’s ability to explain the “truth value” of study findings increases the confidence in results (Polit & Beck, 2012; Streubert- Speziale, 2007). The credibility of this research was enhanced by using digitally recorded interviews that were transcribed verbatim, two primary sources of data (transcripts and reflective memos), and member checking. Interviews were transcribed verbatim to reflect participants’ voice. Member checking was employed to ensure descriptive validity. It involved sending summarized findings to participants to ensure they accurately reflected their experiences and thoughts. Feedback received from participants validated the final themes. The researcher’s reflexive notes also contributed to the study’s credibility as it helped to provide an audit trail about the data analysis process and make the researcher more aware of possible influences on the study (Jeanfreau & Jack, 2010).

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Dependability. The term dependability refers to how reliable the methodological process will be in obtaining a similar result when repeated within a similar context with the same participants (Polit & Beck, 2012; Shenton, 2004). Details have been provided of all processes conducted within the study to ensure that this study was dependable.

Confirmability. Polit and Beck (2012) assert that it is the potential for congruence between two or more independent individuals regarding data accuracy or meaning. This definition implies that the researcher must ensure the findings reflect the experiences and voices of the participants, void of the researcher's assumptions and thoughts. Strategies such as verbatim interview transcripts, reflective journals, as well as reporting the researcher's decision making, how themes emerged, and data analysis process were done to ensure findings are free from researcher biases. Furthermore, the researcher and the advisor independently analyzed several transcripts. The researcher and advisor compared and contrasted codes, categories, and themes to augment confirmability.

Transferability. This term refers to whether the findings of the study are capable of fitting outside the study context or being applied to other contexts or groups (Streubert-Spezaile, 2007; Streubert & Carpenter, 2011). For example, the findings may be transferable to undergraduate nursing students that acquired similar educational strategies in similar clinical contexts. To enhance the transferability of findings, the sample selected had adequate knowledge of the concept under study and prompts were used to elicit rich information from the participants. Furthermore, the researcher has provided an accurate and rich 'reflective commentary' to guide the evaluation of the data analysis process.

Dissemination Plan

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Knowledge translation is vital for the uptake and implementation of evidence-based information. In this view, the researcher will utilize various media to showcase the study finding to advance knowledge translation and uptake in both nursing and communication fields. Upon completion of the study, I will upload the approved thesis on the University of Manitoba, M- Space for findings to be accessible by all. The study's findings will also be documented in manuscripts for publication in peer-reviewed journals. Findings will also be presented at the Manitoba Centre for Nursing and Health Research as well as other Intercultural, Education, or Nursing conferences like the Biennial Convention organized by the Sigma Theta Tau International. Interested participants will also receive an executive summary of findings. A poster highlighting findings will be posted on the College of Nursing boards for information to be shared with all students and faculty.

Since the major stakeholders of this study are nurse educators, I intend to share my findings with nursing faculty, organize meetings with them to discuss my study finding, and consider ways of improving ICC content in curricula as well as best teaching strategies to facilitate ICC learning and knowledge uptake. If possible, study findings will be developed into a simulation video to enhance ICC knowledge and skills for nursing practice.

Chapter Summary

This chapter provided a detailed report on the research design, setting, sampling, data collection, and data analysis. The philosophical underpinning of the qualitative descriptive design was also provided. The processes involved in ethics application and consideration were also described. Information on how to enhance the trustworthiness of the study as well as the dissemination plan for the findings was discussed.

Chapter Four: Findings

This chapter provides information about the study participants and the themes that emerged from data analysis. It describes the characteristics of the participants. It provides information about those who took part in the study: their gender, age, languages spoken, educational backgrounds, and their self-rating of experience with intercultural communication encounters. Five themes emerged from the transcripts and reflective journals. Direct quotes and phrases were used to provide descriptions that were reflective of participants' perceptions of ICC.

Demographic Characteristics of Study Sample

The purposive sample was comprised of 10 fourth-year nursing students who were enrolled in an undergraduate nursing program. These students had undergone various forms of teaching pedagogies and strategies in a four-year undergraduate baccalaureate program which included didactic lessons, laboratory simulations, and clinical practicums. The sample was entirely female with over 80% between the ages of 20-24 years. See **figure 5**.

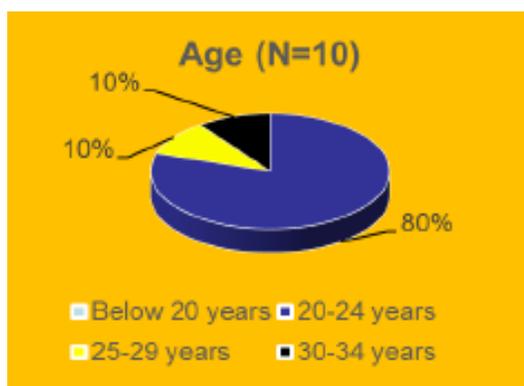


Figure 5. Age of participants

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When participants were asked questions regarding their use of language, 80% of them considered English as a primary language that they spoke anytime. Two participants (20%) identified that they had other languages as their primary language (See **figure 6**). Half of the sample (50%) spoke two or more languages which included English language and another adopted language. Only 10% of participants had had a bachelor's education before being enrolled in nursing school.

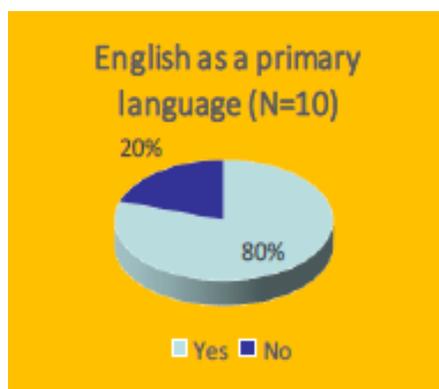


Figure 6. English as a primary language

Participants were asked to rate their experiences with other cultures based on their level of exposure. The survey tool used the following: limited, average, and above average to describe their experiences. 'Limited' means participants have had no or very few exposures to other cultures and may lack knowledge or skills in interacting with diverse cultures. 'Average' means participants have had quite a few interactions with different ethnicities and may be good at communicating with them. 'Above average' means that the number of participants' exposure to culturally diverse people was beyond the expected number which made them more knowledgeable and confident to interact with different cultures. All participants rated themselves as either average (70%) or above average (30%) regarding their experience with culturally diverse people. Forty percent of participants rated themselves as having average

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knowledge on ICC, while 30% had above average knowledge on ICC. Still, 30% reported having limited knowledge of ICC and 20% identified that they had difficulty facilitating ICC. Notwithstanding, 70% of participants perceived that they could facilitate ICC at an average level and 10% identified that they could facilitate ICC at an exceptional level. See **figure 7**.

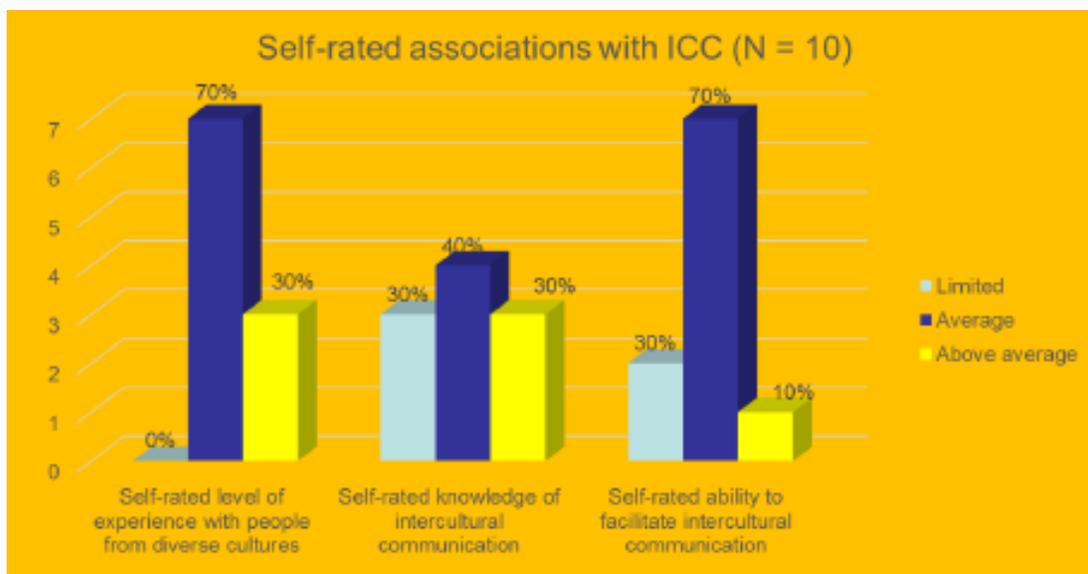


Figure 7. Self-rated associations with ICC

“One Size Does Not Fit All” – Nursing Students’ Perceptions of ICC

The overarching theme was “one size does not fit all” and it was comprised of five themes that emerged from all the data. The diagram below provides a summary of the various themes and sub-themes. All participant names used under the detailed report of findings are pseudonyms.

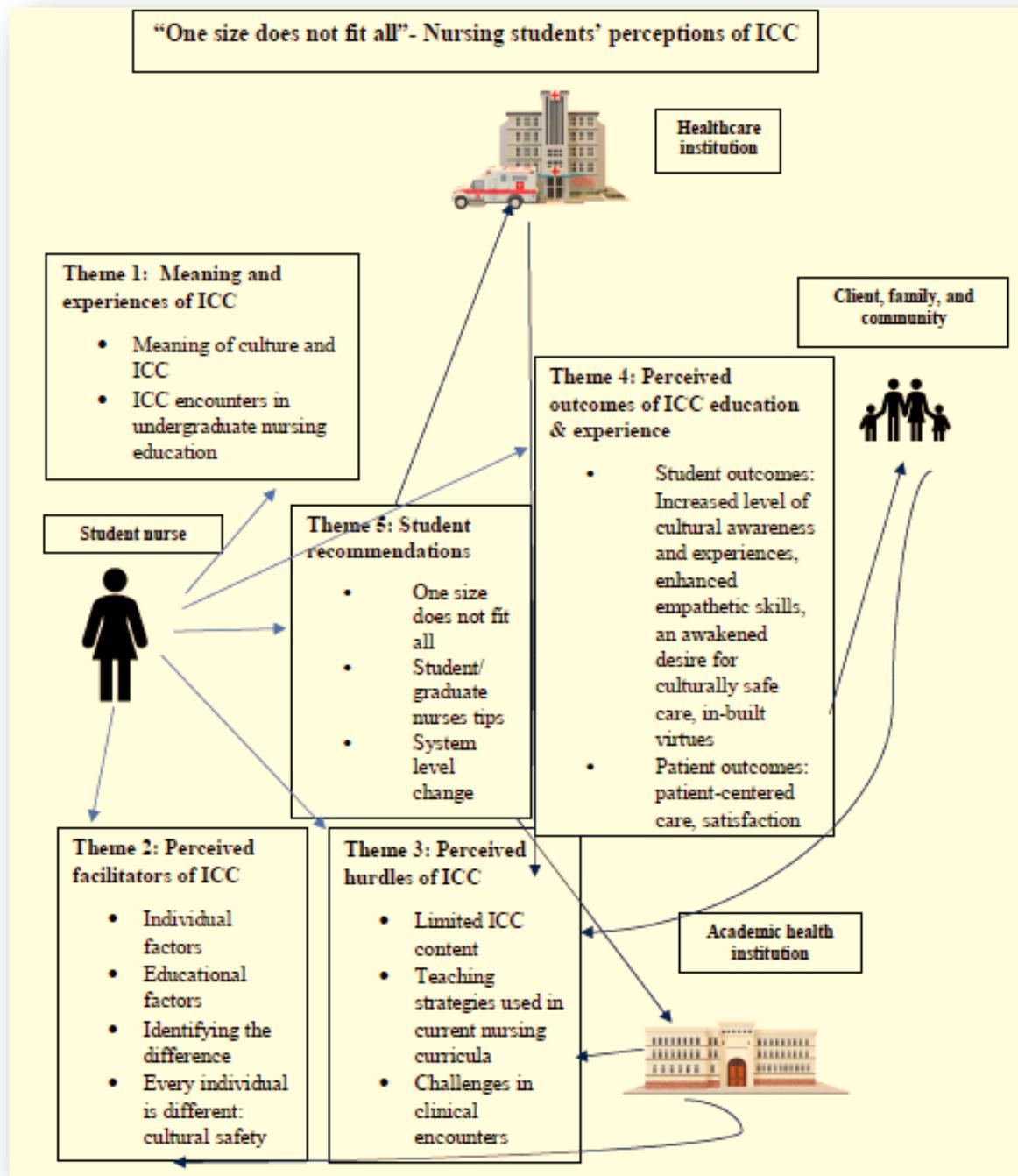


Figure 8. Summary of themes and sub-themes

Theme 1: Meaning and Experiences of ICC

Meaning of culture and ICC. Participants had various definitions for both culture and ICC, which may be due to their context, background, or their level of knowledge on the concept. However, most of the elements of their definition were similar. One participant said,

Culture would be to me like a person, it's so hard to define I find, the person's, um, upbringing, their background, their ethnicity, their religion, their, um, spirituality, just like their family, how they were brought up. Their values and beliefs. Feel like culture would kind of influence all or be influenced by all of those different areas. (Joey)

In defining and describing culture, another person iterated the interrelation between culture and its impact on communication with people from different backgrounds.

it depends on what type of culture you come from. Um. Like knowing like if your culture's very like closed knit and, um, you haven't really been exposed to a lot in the world, you're not really going to know what, um, ICC is or maybe you have that confidence already, but you might not know that you do. (Montana)

Participants provided definitions for ICC at the initial part of the interview which signified their understanding of the concept. Keywords extracted from the descriptions included verbal and non-verbal, exchange of messages, interaction, different cultures, adjustment, worldviews, appreciate, understand, and cultural safety. Pearl shared, “ICC would refer to the exchange of messages either verbal or nonverbal between two or more people from different cultures.” Thus, she referred to it as an interaction with a dialogue in which people originate from different cultural backgrounds, and their interaction could be in various forms. Participants noted that ICC depends on the parties involved to adjust their perspectives to

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accommodate and effectively convey their message to each other. Alex explained that it is “... *being able to communicate with people from different cultures and adjust, um, your communication skills to be able to get the message across to them.*” Laura adds that this further requires recognizing the differences and adapting to them. “*I guess it would mean just like being cognizant of the other person you’re communicating with. ... And trying to understand like the differences that there may be.*” Lisa also spoke about the diversity in world views which influences one’s actions.

I think what first comes to mind is, uh, different cultures. Uh. People who are coming from different backgrounds and how, uh, each person has their own, um, I would say like, I want to say separate worlds, but they have their own like views. Their own beliefs. Their own, um, ways of doing things and how even they think differently of different concepts. (Lisa)

Another participant explained ICC as promoting cultural safety.

Cultural safety and keeping that in mind when, uh, communicating with different types of patients or just like in your everyday life. Um. Acknowledging, uh, your own biases or prejudices in like your own privilege. And, um, thinking about that when you’re communicating with others who come from different backgrounds than you. (Joey)

According to this participant, cultural safety can be accurately defined by only the client who is being cared for since they are at the receiving end of the care and can evaluate their experience better.

cultural safety to me would mean having an environment defined by the recipient being safe to express their culture and practice their culture and feel like their culture and

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unique circumstances are being acknowledged in their care. So, it would also kind of have to do with patient centered care and centering your plan of care and your treatment around a specific person and the context of their own life. (Joey)

Montana said the nurse must be open to learn, understand and appreciate the client's culture to be able to communicate effectively. According to her, this involves empathizing with, and caring for them appropriately. *"it brings up the idea in my head about, um, basically being open to other cultures and, uh, learning about each one so that you can fully appreciate another person like who you're communicating with."*

ICC encounters in undergraduate nursing education. Most participants shared that they were not provided with an opportunity to care for people from different race or ethnicities. Pearl said: *"Unfortunately I haven't had the opportunity to care for any people who are relatively new to Canada."* Only a handful of participants (40%) reported having had an ICC experience during their practicums. Of these few, they had their clinical ICC encounters on the Family Medical Units, postpartum unit, and labor and delivery units. Their clients were newcomers to Canada who did not speak English and needed translators. Other culturally diverse clients were identified by participants as Aboriginal peoples or people from different countries or continents such as Italians, Africans, East Indians, Russians, etcetera. Participants shared that these clients held unique beliefs, attitudes, and communication patterns which need more probing, attention, and special care initiatives.

Theme 2: Perceived Facilitators of ICC

Individual factors. Participants reported that their culture and personal experiences helped them to facilitate ICC. The factors described in this section includes the way they were

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brought up, their interaction with the world and their experiences traveling and meeting new people.

Culture. Participants identified that one's cultural background and upbringing shape one's learning and actions. Alex conveyed this message in her own words: *"Oh yes. Definitely. Because that's the lens through which you see things. Your culture, your background, your context. ... I think what gives me, um, an urge is being from a different culture"*. Most participants were indirectly exposed to ICC by the way they were nurtured. For example, some participants shared their biracial backgrounds. Laura said, *"I think my mom did a really good job of making sure like I was just fair."* Roberta thinks *"communication is a learned behavior. So, people, um, may learn things from their families and from possibly their culture as well."* while Pearl indicated that, *"My parents come from different backgrounds. Um. So, I've kind of always been open-minded to working with people from different cultural backgrounds."* Lisa shared her thought:

"often times I get stuck thinking in my own culture, uh, and thinking that, um, this is how I do it. And, um, especially that, like my culture is different from the dominant culture and I always face this same when I'm working in groups, uh, with other group members who are from like different cultures or even the dominant culture." (Lisa)

Other participants who were also immigrants had exposure to ICC during periods of socialization with friends, living in residences, or schools. Alex shared that, *"It's just based on like moving from [a different country] here to Canada just being, seeing the different ways that people communicate. Then I knew like, oh there's actually differences when you're from different cultures."* Laura also *"was, uh, involved in like the residence community. So, there's*

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a lot of international students that also lived there ... Um. So, I definitely have experienced, um, intercultural communication there as well.” Roberta also had “... friends from various cultural backgrounds so I do understand that there are different ways of communicating and that it’s very symbolic. It does change from culture to culture.” Tara is also an immigrant and her “... daily interactions are intercultural. ... my cultural norms translate to a great extent to other parts of the world so that can make me understand the perspective of other people more than, um, Canadian born and raised persons.”

Personal experiences shaping ICC interactions. Participants shared some personal experiences that were perceived to shape ICC. Some participants expressed that their exposure to ICC occurred through social media outside the scope of nursing and this exposure helped them more than the academic lessons they received. Alex said: *“I think most of my education is from my own experience and my own self-education but not necessarily in the Nursing curriculum.”* Others shared that their personal experiences of watching the maltreatment of people from culturally diverse groups empowered them to change their mindset and attitudes to render more culturally safe care to their clients. Roberta shared her experience: *“Even for my own, um, personal experience, like, um, as I’ve waited in doctors’ offices, I’ve seen people, I don’t know, looked down upon by other health care staff. And that has made me feel uncomfortable”*. Montana also said:

I think that because I’ve also seen how poorly these people get treated at the, at the hospital because they can’t communicate what’s wrong and then they have to have other people come in and then, you know, the doctor or the nurses, they misinterpret what they are trying to say or, you know, how they’re reacting because they’re in

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excruciating pain, but they're just kind of going like this because it's not appropriate in their culture to, you know, to share it. (Montana)

Educational factors. The institutional factors included how participants were made culturally aware within their nursing program and its impact on their clinical judgment and actions. It further describes the effective teaching pedagogies and strategies that were used to facilitate their ICC encounters.

Participants either read, heard or experienced ICC in their curricula or research processes. They viewed ICC in nursing curricula as very important, using expressions like, “*I would definitely say so*” (Mina), and “*I would say so because culture is one of the spectrum of attributes that make up a person... culture impacts these interactions.*” (Pearl). All but one participant received initial exposure to the topic in their Human Diversity course, during their second year, the second term, where they studied about some cultures. One participant had taken a course on intercultural confidence before starting the nursing program. Mina acknowledged the impact of the Human diversity course and said:

I would definitely say that the Human Diversity course did a good job at, uh, kind of opening up my eyes about that the care you provide for someone versus the culture, there's like a biomedical perspective of care which is like focusing on the physical aspect.

Other courses which highlighted aspects of communication and ICC included Professional Foundations 1, Ethics, and nursing clinical practice.

Cultural awareness: facilitating openness to better health dialogue and delivery.

Participants shared that they were more aware of some cultural differences that may exist, and

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they identified the need to be open to learning to adjust their care. Alex explained that *“Openness and awareness... So now then being aware that they’re different, different, different context, contexts then you open up yourself to be able to learn and working through those different contexts”*. Participants perceived that their nursing education has enhanced their interaction with clients, making them more accommodating. Montana explained that *“It’s made me more open and just more positive when I interact with people from different cultures.... Um. I’m more accepting.”*

Participants identified that ICC education has opened their eyes to look at health care delivery with a different lens. It is not only about biomedical or westernized health care delivery but incorporating other factors such as culture, which can enhance the quality of life of clients.

It really kind of opened my eyes as to, ... if someone identifies with a specific culture, every individual is different. And every individual has different comfort zones and different, um, things that bother them. And so, um, it was really to me about individualizing care... Like me providing, um, culturally safe care would give a lot of benefits to the patient. (Mina)

Patient’s wellbeing and preference and not the nurse. Participants indicated that it is now more of the patient’s welfare and choice and not the nurse’s worldview that is central to patient care, which is the more reason they needed to gain awareness of other cultures. Alex commented,

I can’t just be focused on my way of understanding or my way of communicating because my way can mean a different way to someone else so just being aware of that

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helps me to be open to learning because I can't know everybody's way of communicating.

“Beyond just providing like compassionate care.” To some participants, like Ryan, she advocated that: *“We should be learning about each culture, and how to provide, you know, um, the best care beyond just providing like compassionate care.”* It is essential that nurses acquire information from their clients that will make them provide culturally safe individualized care. According to Mina, *“even if the individual identifies with the culture, you still want to make sure that your care is appropriate to them specifically.”*

Helpful learning opportunities. Some participants highlighted the most significant opportunities they had while learning about dealing with culturally diverse groups. One component that helped them was the fact that they had culturally diverse peers within their cohorts which made it easier to collaborate with fellow students or work with people from different groups to share perspectives on how to address specific issues in clinical practice. Pearl believes that *“... just working with the diverse group of students just really helped us move past that maybe.”* Also, participants identified that simulations, case studies, clinical and community rotations were beneficial and eye-opening.

Talking to people from different cultures is the most helpful. And case studies as well. Like during my Community rotation, I interacted with a lot of people from the Indigenous community and this is where I got the most learning about them as opposed to just reading a textbook.” (Tara)

Furthermore, participants said that the nursing professors/instructors explained the need for multicultural perspectives and valuing other's beliefs helped to see the importance of

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studying the ICC. Alex expressed that *“it just explains the need to have multiple lens through which we speak and view culture rather than just ours.”*

Identifying the differences. Several participants shared that being open, self-reflective, asking culture-specific questions and seeking clarification will let nurses know what the client values and further guide nurses to learn and adjust their care to provide a “culturally safe” care. Pearl further said: *“I think knowing that and then with that question, then you would be able to figure out maybe which patients really value their culture and then kind of go from there.”* Alex also admitted that one *“can’t know everybody’s different culture, intercultural styles of communication. But just having the understanding helps me to be open.... It’s something you observe and adjust your attitudes.”*

One participant shared her experience on how she approaches the client from different cultural backgrounds.

I try to like approach them my standard like how I approach everybody. Um. And I kind of try to find out like what their preferences are and if they’re like lining up with kind of what I already know then that kind of like reinforces it. (Laura)

Tara sought for clarification. *“I try to ask them for clarification if I don’t understand.”* It is likely one may misinterpret the actions of their clients if the nurse lacks awareness or understanding of their culture.

For example, if you have. Like a First Nations patient who wants to do smudging or they want to, uh, go somewhere out of their room to do something, you want to like know the context of that and know how to incorporate their culture into their care. Um. So, I think

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actually in practice like that would be more influential because I think it sticks with you more. (Joey)

Every individual is different: cultural safety. Participants identified that culturally safe care prompts the need to individualize patient care, and that is what participants have learned from their nursing program. Mina said: *“even if someone identifies with a specific culture, every individual is different ... it was really to me about individualizing care.”* Participants expressed that everyone has a unique cultural belief and values and therefore holistic care planning for everyone must incorporate the social determinants of health.

It kind of reminds me to think about culture and how it influences care and also how like it would interplay with like their social determinants of health ... I think it's had a positive impact because I'm more able to like think of it and before going into a situation or just like keeping it at the back of your mind or tailoring your assessments and your interventions to that patient definitely will have a higher success and better outcomes and better relationships. (Joey)

Participants, however, recommended that those who teach and facilitate their clinical sessions will also be equipped with the necessary knowledge and skill to promote cultural safety practices among students, and this includes their Clinical Education Facilitators (CEF). Roberta said, *“it also is important too that the CEF is also very culturally safe because there have been instances where the CEFs maybe they've graduated a while ago, or they're just not as aware either.”*

Theme 3: Perceived Hurdles of ICC

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Limited ICC content. Many participants (90%) expressed their dissatisfaction with the limited amount of ICC content in the nursing program. Statements such as “... *it was covered in Human Diversity. It was like mentioned a couple of other times, but like I just, I don't think that's enough on its own.*” (Laura), “*I'm not sure if ICC was explicitly mentioned.*” (Mina), “*I feel like we learn, we don't learn super specific differences.*” (Joey), “*No I don't think so... it wasn't in-depth enough about ICC.*” (Montana). According to Pearl, she only observed one interaction taking place between a nurse and a culturally diverse client once throughout her practicum. She said: “*I only had the one instance of kind of being a background observer for an individual. Um. I didn't really interact with her directly.*”

Participants who were immigrants felt their background helped them to effectively interact using ICC. According to these participants, they do not think Canadian born student nurses acquired enough knowledge and skills from the course contents. Alex said: “*I don't know how it would be for Caucasian students, like Canadian students, if they feel like they have gotten enough education on that.*”

Only one participant shared that the curriculum was adequate. The ICC content was perceived to provide nursing students with a base knowledge which could be developed as students progress through the four-year program.

Yes, and no. Like I feel, um that it definitely provided that foundation, which I've been able to build off of. Um. And then, then kind of I've taken what I've learned and just worked with it. So, yes, it has. But then also my own, um, you know, practicing with ICC has also helped as well.

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Overall, participants described how numerous factors contributed to their success with ICC.

I think just for me like through my previous upbringing, my experience with the residents' community, um, my like travel experience like all that combined has helped me. And like made me I think very good at communicating with different cultures, but I don't think it was like the program alone. (Laura)

According to participants, their exposure to traveling, family, friends, and environment made more visible impacts. Alex said: *"I think most of my education is from my own experience and my own self-education but not necessarily in the Nursing curriculum."*

Participants recalled that ICC had only a few hours allocation in the courses and they perceived that there is a need to include ICC in other classes. For instance, Montana said: *"And mind you it was only a few hours once a week for one semester. So, I think if it was spread out in more courses, not just that one, that it would be a lot more thorough."*

The last paragraph above prompted the need to probe more on the source of their ICC knowledge and how best nursing students felt educators could enhance the nursing curricula to support them effectively.

Most participants expanded on some of the topics or key areas highlighted in the courses they took which had embedded elements of ICC. Most of them feel ICC was not taught as a concept on its own. For instance, *"I don't even think it was treated as a concept. It was more just like an example for a concept."* (Laura). *"We kind of focused a lot around, um, cultural safety ... Learning kind of how to provide, um, effective and appropriate care to, um, people. ... We didn't really study like specific cultures."* (Mina). Communication was

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mentioned mostly in their courses. Pearl said: *“communication has been a recurring theme throughout all of my Nursing program.”*, while Mina shared that, *“during the Nursing program they talked about communication, communication, communication. And one theme that comes about there is like people from various backgrounds communicate differently.”* Another area that participants perceived to be a curricular content focus was Aboriginal populations. Ryan expressed that, *“in our human diversity class we talked a lot about Aboriginal experiences. Yea. But we didn’t go in detail with other cultures.”*

Other areas that brought up cultural contents were ‘privileges,’ ‘cultural awareness’ and ‘cultural competence’. Ryan shared that: *“Definitely like I know that, um, from what I learnt about privilege in that class, um, it put a different perspective. Um. Yea. It gave me a different perspective, so it facilitated easier communications perhaps.”* Lisa also *“... think the class was talking about, uh, cultural awareness and cultural competence and, uh, intercultural communication was one of the, yea, that we, or the concepts that we learned in.”* Tara shared that there was not an entire class allocated for ICC. She said: *“it wasn’t a whole class on its own. We were talking about racism and stereotyping, and then we incorporated communication as a way to fight this.”* Roberta reported: *“that kind of more so tapped into different cultures, um, different, um, different things such as LGBT stuff as well.”* And Montana thinks *“it brought up systematic oppression a lot.”*

Teaching strategies used in current nursing curricula. Participants reported that professors or instructors use mostly lectures and pre-class reading materials. Joey said it is *“Mostly lectures. There were some like videos or like pre-class readings that we would watch or that we would read and then videos that we’d watch.”* Participants listed that few other teaching strategies incorporated occasionally were case studies, group discussions, games,

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videos, guest interviews on the history and impact of Indian and Inuit Residential Schools and various beliefs and practices in Aboriginal cultures. The emphasis of these dialogues was not on communication but more of social justice because of the atrocities the Indigenous population in Canada have suffered. Ryan said: *“there was, um, like activities we did in class so on like privilege and trying to see like the experiences of Aboriginal people through a different lens of privilege.”* Very few participants acknowledged that they remember some scenarios in a simulation. However, the ICC content in those simulations was not insufficient to prepare them adequately for clinical ICC encounters. Roberta said: *“There wasn’t necessarily a simulation set out for, um, ICC. However, um, there has been simulations where there have been different cultural groups that we’ve been able to practice that.”* Participants shared that they look forward to more engaging active teaching strategies being used by faculty to impact future nursing students with knowledge and skills on ICC.

Unhelpful learning opportunities. The aspect participants found least helpful while receiving information on ICC were the style of presentation which had less real-life applications. Most of the participants preferred hands-on than just reading textbooks and listening to lectures. Joey did not like one thing. She said: *“lecture style.”*

More so like a hands-on learner. I’m not really, I have a, well a more difficult time reading something and applying it to real life whereas if like I actually see it and I actually experience it, I find that I learn a lot better from that... yea, it taught me kind of the, the background behind the concept and definitely the importance that it plays but, um, in terms of adapting, like incorporating that into my care, I don’t think that it did.

(Mina)

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Participants critiqued their simulations as they perceived that simulations just provided a patient history that did not require more probing and critical thinking into applying cultural context to their care. Alex said: *“The simulation itself doesn’t really incorporate intercultural communication”* while Laura shared, *“There wasn’t very much application.”* Some participants identified that some class activities promoted stereotyping.

Challenges in clinical encounters. Participants expressed that caring for culturally diverse people can be very difficult, challenging and time-consuming. Mina said: *“More difficult I would I say.”* Roberta shared a similar opinion: *“it can be a challenge of first building that communication.”* All participants expressed facing several barriers including the following:

Staff distribution and time constraints. Participants acknowledged that it is difficult to exhibit cultural skills when the nurse-client ratio is disproportional, and nursing students and nurses have numerous tasks.

“like if you have like ten patients you’re caring for and then like four are from, because people from different cultural backgrounds will require more time. And like there’s just that there’s no time. So, the more patients you have, the less time you have to spend and then the less time you’re able to incorporate intercultural communication. You just get snappy and be tired.” (Alex)

When nurses have a high patient load, they don’t have as much time to maybe individually get to know, um, the person or their culture. And then that’s when they do kind of jump into like just assuming or like their biases. (Laura)

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Mina said: *“Sometimes it’s, um, like an unconscious reaction. Like some, you don’t think about it whereas you have to definitely think about your actions more so and how they’re going to affect or come off, across to the client”.*

Moreover, according to Pearl,

The patient might question well why is this nurse just brushing me off? Why is she ‘ignoring’ me. You know what I mean? But, you know, and they might say oh, is it because I’m from this racial background? Is it because they don’t like the way I look or is it because maybe the nurse is racist? But again, it could just be because the nurse is awfully busy.

Other periods, Alex said: *“... when a female is taking care of the male, there’s some things that you can’t do and like non-verbal communication will explain that like to show what they’re uncomfortable with. So being able to adjust in those settings.”*

Lack of cultural awareness, encounters, and skills. One participant shared the perception that culture influences their interactions with both clients and colleagues. Pearl said it: *“impacts how nurses view the patient and how nurses could view other nurses too.”* Mina and Alex also spoke about factors affecting their approach to culturally diverse clients: *“Like some cultures, I feel like if I have a bit more knowledge about them, I could maybe do a bit better of a job.”*, *“Lack of knowledge because not everything you can observe and know how best to communicate with people from different cultural backgrounds.”* Tara said some of them are even *“afraid to ask.”* questions from culturally diverse clients.

Pearl said: *“I think it could be, especially because of the outside power dynamics that exist for me as an Indigenous [person] than say others of a different cultural background.”*

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Moreover, participants feel uncomfortable asking clients who are identified as First Nations for treaty details-

Because it had to do with like paperwork at the hospital. Like filling out a treaty number and I wasn't sure if that individual was Indigenous. But, otherwise, I think it's kind of awkward to ask. Like it's never, I can never find a way to phrase it appropriately.

(Laura)

Some participants like Montana reported that student nurses must probe more to know the “hidden” or non-visible aspects of various cultures of their clients. These cultural elements are deep and unobservable. She said: *“The other one with the Russian guy was, um, it was beliefs and morals because I obviously, I have no idea. And I haven't been around or done, um, enough looking into like Russian culture and like anything.”*

Power dynamics. One participant acknowledged that nurses are usually in positions of power as they have the medical knowledge and skills and can often direct the clients on the best options or plan their care. Pearl said: *“it's kind of interesting because in the nurse-patient relationship, the nurse is typically in a position of power.”* Most participants expressed that nurses most fail to consider client recommendations. Joey explains that: *“sometimes you're so used to like doing best practice and what does the standardized treatments say to do so you'll plan your care around that without actually thinking like what would be best for this individual patient.”* Roberta put it this way, *“But also know that there's contextual factors too.... there is that power differential.”*

Developing empathy versus lack of empathy. Participants indicated that engaging in an ICC becomes easier when nurses can listen, understand and accept their clients' views just as

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they present them. Participants expressed that this includes not making assumptions or being judgmental but putting oneself in their shoes and planning their care appropriately. Montana said:

It's hard to do ICC when you're unable to like fully empathize with people I think... if you don't like your job or you're not, you're not in a good mood and you're not like fully open to what you're doing, um, there's going to be no way that you can do that.

Notwithstanding, some factors were perceived to build their ICC skills. Some of these factors include: having adequate knowledge of the different cultures from their nursing education as well as more culturally diverse opportunities in clinical or simulation. Other significant factors described by participants were having more staffing on their allocated units, adequate time to adapt to caring for culturally diverse clients, ingrained attributes they have learned from nursing, one's cultural background, being paired with an experienced buddy nurse, being friendly and observant, and engaging in experiential learning experiences like the interprofessional communication (IPC) in a First Nation community. Mina said *"I feel like the more practice and experience that I have, the, the better I'll get at it... You do need the time to, to adapt your care to meet any of those, any of the client's specific needs."*

Language differences. From the participants' perspectives, interpreters or translators were not always available, and family members had to act as translators. One participant shared her experience as:

Her family, like her daughters and her granddaughters, um, were there with her. They were kind of acting as like a translator for me... They definitely weren't like medically trained translators. ... Like telling them exactly what I was going to do before doing it

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so that they could hopefully explain it appropriately to their relative but yea... when I had to do like the initial admission assessment and certain questions you could tell, um, she was maybe not like super comfortable. I did like a head to toe, um, and at that time, um, I did ask if it was OK for the daughter and the granddaughters to leave. (Mina)

Two participants also experienced issues related to verbal and non-verbal miscommunication. The language barrier can pose uncomfortable situations when caring for clients who are from a different culture.

This person was from like, um, I think Italian country so I don't know if it's general but what happened is they're very family oriented and like when they talk, sometimes you might think they're fighting because their voices are very like "uuuuuuh", but there is like, like that's just how they talk anyway. So, um, being able to understand. Because initially I was taken aback like is everything OK in the room? But being able to understand that it was a cultural thing. I was able to, OK, understand like there's no issue going on or not take people's tones in a wrong manner. (Alex)

... one patient, for example, he kept picking on me because I didn't understand his slangs when he was talking. Like backpack he was saying, it's a back sack or something else. And I looked stupid to some extent because I didn't understand it. And he wasn't, um, respectful when it came to that. Like he was like, how come you don't know this? It's not my fault that I wasn't raised here to understand the slangs that you say. But actually, after like sh..., realizing that I took good care of him, he was so nice to me by the time he was getting discharged. (Tara)

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Sometimes participants had to struggle through choosing their words carefully to make clients understand what they meant. Alex explained:

... like some words I might use during my head to toe assessment might, could be lost in meaning. Like what do you mean by that? So, like trying, trying to use hand gestures when I was like doing my assessment and explaining in terms that could be easily understood by anyone. Like not, no going into like medical jargon and stuff like that. Just like simple descriptions. And like trying to explain what that means like if, oh, maybe the heart rate was high or it means like maybe him being walking around a lot, like your blood is pumping out more.”

Some participants spent time trying to understand clients because of their accents, expression of pain, and way of life that supports their healing process. Laura shared her experience:

... she had like a heavier accent. So, like it took me, um, like more concentrating just kind of understand like what she was trying to tell me. Um. But she also didn't have like a very high like pain tolerance, um, for her. And what I assumed from her culture as well as like they are supposed to like express when they are like experiencing pain. So, she was getting these staples taken out and so most people kind of like grit their teeth and bear bit. But since I was there just watching, um, she like held my hand because she didn't have a partner there. And would grip it and kind of like, like make more noise than I would say like the average person would. Um. And then the nurse left and so I stayed with her because she recently had her baby. And since she just had the staples taken out, I did something with her baby. And, uh, then she turned on, um, music, like I

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guess her like cultural music. And I was, and then she kind of like started like almost like muttering kind of like praying to herself like while I was doing, um, the stuff with her baby. And so, it was just like at that point I didn't want to like say anything to like interrupt her because like I wasn't quite sure what she was doing because it was in her own language. Um. So I just kind of like, just kind of like talked to the baby and did my thing and because she had her eyes closed and then I kind of had to kind of like gently, be like OK, like excuse me, I'm sorry but is there anything else you like need before like I leave or go out and she would say, oh no. No. I thank you so much. Bless you and all this sort of thing. Um. But, yea, it was just, I kind of had to tiptoe a little bit because I wasn't quite sure what was going on. But I was like trying my best to like respect like what she was doing.

Gender. According to some participants, gender also affected communication especially if their culture prefers receiving care or undergoing assessment under the supervision of someone from the same sex. Laura said:

One of my like other student colleagues, he was caring for a woman and so he like kind of like jumped in too fast one time. Like he had like talked with her a little bit. Um. And like then like making an effort to understand her but then he kind of like jumped kind of straight in to like an assessment which kind of like spooked her a little bit because, like from what I understood afterwards like it sounded like she was uncomfortable like with him being like a male.

Assumptions. ICC encounters occurred in the maternity and child health units as about 50% of participants shared experiences they had on those units. Participants identified

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that most nurses made assumptions based on past experiences and student nurses may observe and pick up these attitudes. Laura shared an experience:

Like on the maternity, like kind of in the labour and delivery triage I was there this week. And one of the nurses, there was a patient that came in again like I think she was East; I believe she was East Indian. Um. And the nurse saw her in triage, and she's like, she said, she' like OK, like not in front of the patient like but at the nursing station. She's like OK, well usually there's two types of East Indian women. There's the ones that give birth like this. And she snapped her fingers. Or there's the ones that are like dying ducks and like they take forever.

Visitors. Communicating vital nursing activities became a challenge to participants when clients had numerous visitors and participants shared that most nursing students do not know how to approach the situation confidently. Laura said:

... there is a mom who had a baby, and she was on the postpartum unit, and she had like visitor after visitor and visitor after visitor. Like all day. She was from an African country. And the baby hadn't, this was like one in the afternoon, two in the afternoon, and the baby hadn't eaten since like 8:30 that morning. Really OK, like we've got to interrupt her because like this baby like has to eat. Like she's got to like breastfeed this baby soon. Um. So, it wasn't my patient. It was like another student's. So, they were having that dilemma of like whether they can interrupt like all these visitors or like tell the mom kind of like, OK, like it's time.

Cultural beliefs. Also, Joey said misinterpreting clients' beliefs could pose a threat to ICC and nursing care.

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It was a baby in their bed, and there was a cigarette in the bed. And I didn't kn..., I was like, oh, like we should take this out of the bed. But then the nurse was like, well we should ask, let's ask them right there and figure out how we can make this a safer environment. So, it was actually there because like tobacco is sacred and they were using the tobacco, um, as like a blessing to, um, have a good, like a good omen kind of ... So, we were able to work with the family and instead of just like leaving a cigarette on the bed of an infant, we put it in a plastic bag and hung it up on the, uh, crib so that it was like out of their reach, but it was still there.

Such ICC experiences created anxiety for participants who did not know how to manage the situation. Mina was *“just like a little more anxious than usual.”* However, they were able to adjust based on their observations and willingness to adjust to caring. Alex said: *“they've been good experiences by being able to observe and adjust accordingly.”*

Theme 4: Perceived Outcomes of ICC Education and Encounters

Every participant acknowledged the need for students to engage in the ICC. They reported how ICC: i) increases the student's cultural awareness and ICC experiences ii) enhances empathetic skills, iii) influences in-built virtues: curiosity, patience, motivation, confidence, global attitude, iv) awakened desire for culturally safe care, v) enhances patient-centered care and health delivery experiences, and vi) improves patient outcome and satisfaction.

Increased level of student's cultural awareness and ICC experiences. Participants reported having an improved level of cultural awareness and ICC experiences of students. They become more aware of the diverse cultures from which their clients relate to, more open to

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appropriately asking culture-specific questions, and it further becomes a norm which they used in their practices. Joey said: *“just being open to asking people questions I think. And like learning about the diversity within the culture.”* Roberta also said:

It’s like the dignity question. Like what do I need to know about you, um, in order to provide the best care? So, um, asking questions that are specific to their culture but not assuming things is an OK thing because it can, in a sense, enhance the care you provide as well....So being able to like practice communication, um, very novice versus still a novice but I am more experienced now I’ve had many opportunities to interact with people all walks of life, and that has really, really helped....I think that it does come to being like practice....it’s again like, uh, like therapeutic touch, for example, can work very well for somebody but some people, it might be deemed as inappropriate. So, uh, like empathy, for example, it just, it’s caring for the person, um, whatever way they want to be cared for. And I think that learning about differences has really helped with that as well.

Enhanced empathetic skills. Participants shared that the knowledge of ICC has created a dynamic relationship between them and their clients and this is based more on a transformation in how they empathize with their clients. For Mina, she stated that ICC has made her *“Definitely more empathetic, more open-minded. Because just the whole thought of like imagining if I was in that situation, how difficult things would be”*. Pearl also learned how to interact with culturally diverse clients, and that has made her more comfortable and confident. She said:

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So now I feel more comfortable if I had to speak and work with someone from a different cultural background just because a lot of these common aspects like respect, compassion, caring, you know that can be transferred over to any patient encounter. ... It just allows us to be better nurses and put the patient, patient's needs safe and being able to acknowledge culture, um, I think adds more context, and it adds more dynamic to the nurse-patient relationship.

Participants perceived that ICC experiences facilitated an improved level of communication and outcomes because they incorporate multidimensional perspectives in their conversations. Lisa said: *"it helped me understand that those people, um, have different cultures, have different attitudes, different, even different circumstances, uh, and their lives could be different in many ways."* Pearl also thinks *"... just being more open to say different viewpoints that might not be the traditional medical nursing viewpoint, being open to those viewpoints and still being able to support a patient in their decisions."* Participants expressed that this could improve clients' experience at health care facilities and yield positive health and emotional outcomes. As Alex explains, *"I think it benefits the patient. Yea. The patient has a better like patient feels safe. Patient feels heard. Patient feels valued."* It has enhanced their relationship building with clients and made their work easier. Laura said: *"I think by like learning all this, it is helpful with just like developing that relationship with them because then like it just makes it, it just makes my job easier."* Tara shared a similar view. She said:

"I can go to them with an open mind and ask them, what do you want me to do? Is there something that you want me to do differently? ... by teaching us about other people and teaching us self-awareness and reflection about who we are, that allows me to be empathetic and to understand other people's perspective.

In-built virtues: curiosity, patience, motivation, confidence, global attitude.

Participants also shared that they have built some virtues throughout their nursing education based on the knowledge they acquired on the various cultures. For instance, their motivation and desire to interact with culturally diverse clients was noted to have increased. Pearl said: *“it has motivated me to be a little bit more open and understanding of the differences between cultures.”* Participants feel more confident to approach clients from different backgrounds, exhibit patience towards them and care for them in a culturally appropriate way. Laura is *“definitely more confident and, uh, it makes me more aware that I do have to be patient. It motivates me a lot. Um. It makes me like want to understand”*. It has also increased their desire to know more about other cultures to gain that global mindset of culturally safe health care delivery. Joey explained in a comment saying: *“it’s motivated me to like learn more about different cultures,”* and Roberta said, *“I’ve become more confident in the sense that, um, I understand that there are difference and asking in an appropriate way and a respectful way is OK.”*

An awakened desire for culturally safe care. Participants revealed that most of their lessons from the human diversity course centered around ‘cultural safety’ and how to provide appropriate care to people. Hence, they perceived that they are now conscious of engaging in activities that will provide more culturally safe care to their clients than focusing on their routine nursing care. Mina said: *“... now it’s more so another side of care is that what things can I do for this patient to provide culturally safe care and not just tick a bunch of things off my list.”* They further yearn to be more culturally safe so that their client can communicate better with them as well as trust them for their care. Roberta expresses her desire as *“... so in a sense*

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being culturally safe so that they feel that they can communicate back to you as well.” Laura “want them to feel safe and like they’re in like a trusting place.”

Patient-centered care and healthcare delivery experiences. In terms of improved patient and nursing care experience, Joey and Mina voiced that, *“it makes care more effective and like saves time in the long run ... it’ll better equip like the medical team to care for somebody if they can individualize that care.”* and *“Is that it is completely individualized to the patient in front of you.”* Additionally, Joey talked about establishing trusting relationships. He said *“It’ll also increase like trust in relationships,”* and therapeutic relationships essential for eliciting information needed for planning and implementing nursing care that are established- *“The benefits to nurses would be like, uh, increased therapeutic relationships so, you’re better able to, um, communicate with your client and get like the information that you need.”*

Improved patient outcome and satisfaction. Further to the above, participants shared that hospital staff can meet patient goals and render satisfactory and culturally safe services. Mina said: *“I feel like it’ll just improve patient outcomes when you’re working as a nurse in a facility or improving patient satisfaction.”* Roberta and Joey also talked about patients having trust in the health care system. They indicated that effective ICC further increases clients’ confidence in the healthcare system and make them more compliant to treatments, thereby reducing hospital re-admissions.

It’s beneficial to patients, first of all, because they’re the ones who are being cared for and if you are being culturally safe to them, um, and building that ICC and that therapeutic relationship not only improves quality of life and trust in the health care field. (Roberta)

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They have more trust in you. ... if you thought about their culture and their plan of care for when they leave, then their follow-up care, they'll be more, I don't like the word compliant, but like compliant and reduce re-admissions and stuff. (Joey)

Joey and Mina perceived that patients and family caregivers leave the facility with gratitude for the holistic care they received. Joey said: *"They'll feel like they're being cared for. It'll feel like holistic care."* while Mina said: *"Her family was, and her, were very, very thankful to me."*

Theme 5: Students Recommendations

Given the knowledge, skills, and abilities, participants had acquired through their education and experience, they recommended the following to future students, nurse graduates, and faculty.

"One size does not fit all." Participants advocated for individualized care that values clients' culture and incorporates their needs. They explained that clients would feel more dignified when treated as unique individuals. They further added that this involves incorporating the client's values and needs into their plan of care. Pearl advises that we *"Respect everyone regardless of their culture."* Joey also said: *"look at everybody as unique and incorporating that into your care. I don't think would be more difficult or.... it's not just like one size fits all."* Furthermore, Montana said, *"I think the students and lecturers, you know, should be a bit more empathetic, um, when things don't go their specific way."*

Student/ graduate nurses tips.

Be observant, simple, and ask the right questions. Some participants shared that communication involves non-verbal cues as well. Hence, health workers must observe for signs

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showing participants' discomfort or sense of satisfaction while delivery care and making the necessary changes to their dialogue or care. Mina said,

So just always being aware of, and watching the signals too for, if someone is uncomfortable. ... Making adjustments to how I interact and how I present myself, um, to meet the needs of the, the client to whatever they find, um, comfortable.

They also expressed the need to avoid medical jargon and use simple terms that clients can relate and understand better. When clients understand their care, they give reliable information and consent. *“So just using simpler terms that have shared meaning.”* (Alex)

Additionally, they advised that student nurses ask the right questions. Participants feel this is achievable during assessments or when in conversations with clients. Joey thinks *“it goes beyond just like the theory of it and, um, knowing what the specific questions to ask.”* This participant cited a sample question, *“what is there about your culture that I should know when planning your care or what’s the most important thing, uh, about you that I should know.”* The participants perceive that right questions will help student nurses plan care of their clients better. Joey thinks, *“it’ll actually be more effective in the long run if you take like a little bit of extra time at the beginning.”* Most participants feel that more time should be invested in the health assessment process to elicit vital information.

“Be open-minded”. Participants shared that seeking for more knowledge makes one open minded to accepting the views of other people from different backgrounds. Tara advised all to *“Just be open-minded.”* Canada multicultural population requires the adoption of this skill or attitude in the health workforce. Alex conveyed this message by saying:

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“Be open to learning and don’t ever focus on your own lens as the only way to see things or the only way to incorporate things. There is one million ways of interpreting the same thing, I think. So just be open to learning and always clarify... Remember that Canada is full of people from like a lot of different cultures, so you’re always going to come across people from different cultures. So look for opportunities to be able to build to yourself up in that intercultural communication.”

Do not judge or impose; adjust your care and aim for culturally safe care. Almost every participant had a piece of advice regarding this sub-theme. Roberta acknowledged that *“there’s also differences within that culture too. So it’s good not to make stereotypes as well.”* Lisa said one: *“... have to be aware that I’m not imposing my, um, values or my beliefs on other people.”* According to Alex, health professionals and faculty need to know that *“the cultural differences are not said. It’s something you observe and adjust your attitudes.”* Tara said you *“need to ask your client directly about who they are rather than making assumptions on your own.”* and *“don’t judge a book by its cover”* (Montana).

Just please don’t make assumptions about people, whether it’s regarding their race or culture, based on their appearance. And just because someone identifies that they’re from a specific culture, doesn’t mean that they share characteristics or attributes with everyone in that culture. Each individual is unique and if you have the opportunity as a nurse, you know, get to know your patient. And I feel as though that would benefit their health and wellbeing overall, especially if they are being cared for by a culturally safe nurse. (Pearl)

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Cultural safety and keeping that in mind when, uh, communicating with different types of patients or just like in your everyday life. Um. Acknowledging, uh, your own biases or prejudices in like your own privilege. And, um, thinking about that when you're communicating with others who come from different backgrounds than you. (Joey)

Also check your own biases as like an instructor, um, because you are teaching such a range of students as well... like CEFs, I don't know what kind of training they get versus like instructors. Like they should be culturally safe as well. But they do come in with their own biases, but also they influence such a large nursing student population."

(Roberta)

System level change.

Academic health institution reforms. Active learning and teaching strategies, curricula and faculty upgrades were proposed by the participants. They believe that it will change their scope of education and practices in terms of ICC.

Proposed active teaching and learning strategies. Over 90% of the participants recommended the use of case studies, videos, culturally diverse guest lecturers, role play, simulations with real people, or even using their culturally diverse colleagues in class discussions. Ryan thinks what they need is *"Like more of an experiential learning."* Mina also thinks *"incorporating case studies. ... Role-playing even. Um. Things like that where it kind of gets you thinking. That would be nice if they could incorporate that somehow into the simulation experience so."* Participants perceive that these strategies keep all types of student learners actively engaged in class, thereby serving the purpose of their presence in class and future professional applications. Another area that they proposed that of active student

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involvement in research and experiential workshops. These, to them, provide more emotional and stimulating desire to work with culturally diverse clients. Joey proposed *“doing simulation, participating in like experiential workshops, like building bridges or, um, working as a research assistant for Ellie [pseudonym]. Her research focuses on like a lot of I would say culture.”*

Pearl feels ICC

... should be like somewhere in the actual like curriculum. ... having that theory and the definition, maybe techniques on how to approach people, and then actually having to do that in either simulation or clinical. ... Maybe it should be mentioned to the CEFs that maybe throughout the rotation to try and pair students with different people, um, from different cultural backgrounds if the opportunity arises.”

Some participants are tactile learners and would appreciate more practical learning. Tara said, *“I like learning by doing so the best way to develop my ICC skills is by actually interacting with people from other cultures.”* Alex suggested that *“during simulation, they should be real people. I know there’s mannequins for the communication one. ... if there is a student that’s from China, why don’t they lead on like the key things in communication rather than their professor.”* Participants also proposed that simulations should be made with culturally diverse clients and should incorporate activities like interviewing standardized patients. Laura said,

Or even just like having the person like react in a way because like there’s always a person speaking through the mannequin. Like having them react in a way like that makes the student uncomfortable. Like I know everyone believes, like scared going into

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sims as it is and like some people, it like makes them anxious but, like I don't know, maybe by putting them on the spot that way it would like prepare them for like getting put on the spot.

According to participants, ICC information should not be limited to classroom teaching only. Gaining practical skills is essential to providing them with further ICC skills. Laura said: *“it's just like putting us in situations where we like have to apply them.”* CEFs have a part to play in building the ICC competencies of nursing students. Participants said, CEFs usually allocate patients based on their disease condition. Alex explained that *“It's more of like their diseases. How heavy a patient is. The CEFs use to assign. So that would be a good indicator to look for patients from different backgrounds in addition to how heavy they are.”* Roberta recommended that,

... if you have one of your patients is assigned maybe from a cultural background, maybe the CEF can like talk about like how you may interact with that person. And then that kind of gives you like a foundation before you kind of go in to talk to that person.

The participants hope there will be a change in terms of patient assignments to include more diversity and the CEFs will be more prepared to guide them in multiple ICC encounters.

Curricula revisions. They further recommended that curricula content must be generalized and diverse. They said all courses should focus on creating a culturally safe mindset for the future nurse. Roberta said, *“And I do find that being culturally safe and having courses that generate cultural safety definitely helps as well.”* Montana suggested *“incorporating ICC in, um, more than just one course.”* Tara highlighted how courses that teach on culture must be revised to incorporate other cultures.

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One thing that can be added to the program is, um, like we focus so much on Indigenous culture which is a great thing. That's humanly important because of the trauma that they have dealt with and how this affects who they are now. But also, we can incorporate more learning towards cultural diversity in general because there are so many immigrants that, that education is not geared towards.... learn about what culture means. What's the difference between individualistic culture versus a collectivistic culture? So, a simple, um, definition of these two things, for example, can allow others to understand why families get so involved with the patient while in other cultures that's not the case.

Participants proposed that there should be another course to feature ICC education besides the human diversity course. Montana thinks that,

that concept needs to be brought up in like Child, whatever maternity and child health. Like that course would fit perfectly with. Um. So, like you know how different cultures and different religions how they, uh, react to giving birth and what is exp..., you know what they expect, um, and what is inappropriate when you are helping the women give birth. ... Another course would be, uh, we had a palliative course in third year. That would have been perfect as well to put ICC in there because each culture deals with death differently.

They also suggested that there could be electives or extra courses to boost their cultural competency skills. Montana expanded on her suggestion saying,

for us who are in, uh, our program now, to have a more dedicated course to that or at least a part or like an option, you know, like I, like to have like a Bachelor of Nursing

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Honours and you have like these extra courses that you can take to get those honours.

Like, do an extra summer or something.

Mentorship. Mentorship was another important sub-theme recommended by participants. Participants believe pairing nursing students with their colleagues or faculty who are of a different cultural background could improve their knowledge, skills, and confidence to interact with other culturally diverse clients. Laura said,

it would be really neat if in Nursing you had like, like a cultural like buddy. Like I know there's like the mentorship program for like second and fourth years or whatever. But it would also be I think neat if there is like some sort of program that like paired you up with someone just like from a totally different culture.

Diverse faculty. Participants would love a culturally diverse teaching group who will provide variable teaching perspectives and experiences rather than all Caucasian professors. Laura expressed her concern saying: *“But like at least have, over the course of like the whole Nursing program, at least have like at least two other people speak to you that like aren't like a white middle-aged nurse.”* To this, Montana suggested organizing *“mandatory training”* workshops and providing resources to faculty. As well, Tara suggested *“we can raise awareness and like maybe do workshops with like current staff about how they can deal with these situations.”*

Interprofessional or inter-health faculty collaboration. Furthermore, they proposed that health faculties who train health professionals come together to draw strategic measures which build teamwork towards ICC competencies of health professional students. Joey said:

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I'm not sure how much of ICC is integrated into other health sciences faculties, but I think more, maybe making it more of a interprofessional initiative as well could be something that would like even enhance outcomes more and build relationships. ... trying to like have educational initiatives together along with other faculties and/or simulation activities would help make things more realistic and lead to a better relationship like with the whole health care team which I think is something that you would need.

Healthcare institutional reforms. Participants believed that these system reforms would involve both academics, health professionals, policy and health initiatives.

Health assessment. About 40% of participants suggested that there should be an item on the health history/assessment interview form which probes into one's culture and what their preferences are for care. With this, Pearl said, *"I think there could be, like an area like regarding culture on there. It's just trying to figure out how to ask a patient that, you know.*

"Similarly, Joey thinks:

"there would definitely have to be more of a system level change like of it being more of a priority within like, for example, like in acute care setting, ...If it was incorporated into like, maybe like admission assessments more or like discharges like to know how their culture impacts how their follow up care would be like in the community."

Participants suggested that there should be avenues to educate health professionals on how to ask the culture-specific questions in an appropriately to elicit more information that will help in planning care during admissions and discharges.

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Professional development courses. Participants perceived that most nurse graduates who are out of school and currently working may lack knowledge on ICC and skills to handle complex cultural situations that may arise at their workplaces. Hence, they believe the introduction of culturally relevant courses or training workshops will enable them to update their knowledge while building those missing skills. Montana said:

People need to be trained in ICC. Like some people don't know and I think that would be really good if, if people, um, who are not in school now and didn't have a course on it, should be re-educated about it.

Adapting to care. According to participants, there is a need to change health care practices if we want to include diversity in health care delivery. They proposed that the health system incorporates cultural practices that can help improve patients' recovery as part of the biomedical system. Roberta is optimistic that,

there can be like culturally, cultural practices that maybe aren't practiced in the, for example, westernized hospital that could be implemented to better care for somebody. Like increase a person's quality of life and improve somebody's health in general as well.

Chapter Summary

This chapter provided a detailed report on the findings obtained from the data collected. The findings in this chapter have been reported mainly under two headings: demographic characteristics of participants and the overarching theme, "one size does not fit all" with its five themes.

Chapter Five: Discussion

This chapter discusses the findings of the study in comparison with the existing literature and the Integrated Model of Intercultural Communication Competence. The perspectives shared by participants on intercultural communication (ICC) in their nursing program provided first-hand information to add to the existing literature regarding the appropriateness of incorporating ICC in nursing curricula. The two main research questions: a. What are undergraduate nursing students' perceptions of ICC in the nursing education program? and b. How has exposure to ICC in the nursing curricula impacted undergraduate nursing students' abilities to care for culturally diverse patients, families, and communities?, are discussed in depth concerning participants' responses to understand the need for, facilitators, challenges, and impacts of ICC in their program. Significant demographic data is also discussed.

The first theme, which is *Meaning, and Experiences of ICC* had some sub-themes which reflected definitions of ICC. However, the clinical experiences shared by participants with regards to their care for culturally diverse clients remains rich despite their limited exposure. Also, significant among the findings were themes such as: *Perceived facilitators of ICC, Perceived hurdles of ICC, Perceived outcomes of ICC education and experiences, and Students' recommendations*. These were unique as none of such information had been reported in existing literature. The strengths and limitations, as well as the implications of the study for nurse educators, nursing practice, stakeholders within health education and health institutions, health policymakers and researchers are discussed. A conclusion drawn from the study discussions is provided. The chapter ends with recommendations for nursing education, clinical practice, and further research.

Demographic Characteristics of Participants

The demographic data indicated that 80% of participants were between the ages of 20-24 years and 10% between the ages of 25-29 years. Additionally, 10% of participants had had a bachelor's education before commencing nursing school. This finding is partly consistent with the results of Riley, Smyer, and York (2012). Their study indicated that nurses between the ages of 20-30 years and who were entering a Registered Nurse- Bachelor of Science in Nursing (RN-BSN) program had a significantly higher score for cultural skills when assessed with the Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals-Revised (IAPCC-R). Campinha-Bacote defines cultural skills as "the ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally based physical assessment" (2002, p.182).

Considering the result of Riley et al. (2012), it is suggestive that if an individual attends a university or college prior to nursing school there could be an exposure to other cultures in previous classes, provinces or countries of education, faculty, course content, amidst others, irrespective of the location of the university, the program of study, or ethnicities in their classes. Such exposure can impact how participants relate with, communicate or adjust with people from other cultures. However, the age group for the current study's sample are all fully engaged in a Bachelor of Nursing (BN) and are near completion. This finding calls for further research to investigate whether nursing student gains more cultural exposure in a community college setting as compared to a university setting.

Furthermore, all participants rated themselves either as average (70%) or above average (30%) regarding their experience with culturally diverse people. This self-rated report

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was interesting as it meant that every participant had had numerous encounters with a person from a different culture (s).

In furtherance with the above, 40% of participants rated themselves as having average knowledge on ICC, while 30% had above average knowledge on ICC. Still, 30% reported having limited knowledge on ICC, and 20% had difficulty facilitating ICC. Notwithstanding, 70% of participants could facilitate ICC at an average level and 10% at an exceptional level. These findings demonstrate the extent to which fourth-year nursing students perceive their knowledge, and abilities related to ICC encounters. The subjective responses from the qualitative interviews provided further insight and support into these quantitative responses.

Undergraduate Nursing Students' Perspectives of ICC

This section discusses the findings of the first research question: What are undergraduate nursing students' perceptions of ICC in the nursing education program? This study enhanced the body of literature on ICC by shedding more light on the perspectives of undergraduate nursing students who have received some education on ICC. There were few consistencies observed with the literature regarding ICC which may be because there is a dearth of empirical studies focused on this area of research.

Meaning of culture and ICC. Many academic health institutions have introduced transcultural nursing courses or concepts in their curriculum (Carlton, Ryan, Ali, & Kelsey, 2007; Rowan et al., 2013). Kale and Syed (2010) recommended that healthcare providers and institutions have a legal responsibility to ensure that there are sufficient levels of communication with their clients. Their suggestion implies that there must be awareness creation to equip healthcare providers like nurses with the knowledge needed to communicate

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effectively with culturally diverse clients so that they do not falter in their responsibilities.

Based on the participants' knowledge and experiences with ICC, they shared their definition of culture and ICC.

Cortis (2003) reported that there is no unified definition of culture. Interestingly, the study findings demonstrated that student nurses had varying definitions of culture and different perspectives on ICC. Some participants expressed that culture was challenging to define while others understood it in the context of either one's upbringing, ethnicity, religion, spirituality, values and belief systems. The participants reported that one's cultural background, whether individualistic or collectivistic, will determine a person's exposure to diverse cultures and how they communicate between cultures. This finding is consistent with previous studies done by Leininger and McFarland (2002) and Sully and Dallas (2005). Leininger and McFarland (2002) expressed culture as the learned, shared and transmitted knowledge of values, beliefs and lifeways of a group that are generally transmitted intergenerationally and influences thinking, decisions, and actions in patterned or in certain ways. Sully and Dallas also described it as organizations, professions, and groups that have shared assumptions and beliefs which link with the shared values held which produces shared norms that govern patterns of behavior (Sully & Dallas, 2005). Linking the views of participants to that of Leininger, McFarland, Sully and Dallas, it is evident that composites of culture can be passed on intergenerationally. Hence, nursing students may adopt a similar or multicultural way of life through their upbringing. Likewise, this cultural knowledge can be transmitted through associations with various institutions like the college of nursing to influence the pattern of a nursing student's behavior. It is, therefore, imperative of nurse educators to know how best to integrate culture in nursing curriculum and teaching methods to use to translate knowledge into action.

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ICC, on the other hand, was referred to as involving an exchange of messages with people from different culture. Participants explained that the message could be verbal or non-verbal; however, one may need to recognize and understand the differences that exist between and within cultures, and as well, adjust their communication skills to be able to send their message across to the other effectively. This finding is consistent with the information provided by Kourkouta and Papathanasiou (2014) that one can engage in effective communication when he or she understands the patient as an individual, their experiences, and accept them as they are. An individual's personality includes culture, and therefore culture must be considered in the holistic care of every individual. This finding also implies that the nurse must be culturally aware of the other and adjust their own biases to be acceptive of the other person in the communication process within any given clinical situation (Jeong et al., 2011).

Participants also associated ICC with cultural safety. They perceived that engaging in ICC makes one's care delivery culturally safe. One's care becomes culturally safe because the nurse becomes cognizant of the client's culture and plans and delivers patient-centered care specific to the individual's cultural needs and preferences. This response is congruent with the finding that effective communication must be highly esteemed if quality and safe care are to be provided (Kourkouta & Papathanasiou, 2014). According to the participants, being open to learning from other cultures enables the nurse to engage in culturally safe practices. Interestingly, no study was found to have explored the perceptions of student nurses of culture and ICC definitions, but only one study assessed strategies they use to address ICC challenges (Henderson, Barker, & Mak, 2016).

About 90% of study participants reported that the ICC content in their nursing curricula was inadequate to prepare them for ICC encounters adequately. Considering the

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responses of participants that “It was not enough,” many participants encountered difficulties while caring for culturally diverse clients, which may not have been addressed in their nursing program. They reported having heard the concept in only one to two courses within the nursing program. According to them, their Human Diversity course had some content on ICC. Topics discussed included communication, cultural safety, Aboriginal populations and experiences, privileges, cultural awareness, cultural competence and systemic oppression. Moreover, only a few hours were allocated for ICC in these courses. However, they believe this limited content will serve as a foundation for future practices. They recommend introducing ICC in several program courses across the nursing curriculum and allocating more hours for maximum impact.

This finding could relate to the limited literature on best teaching strategies to integrate cultural interventions like ICC into lesson delivery for undergraduate nursing students (Jeong et al., 2011, Miguel & Rogan, 2013, Kourkouta & Papathanasiou, 2014). Chen et al. (2018) found that predictors of cultural competency were cultural knowledge and encounters. Their finding implies that faculty will need to intensify strategies that promote this knowledge and experiences to enable students to receive better education outcomes for future practices.

Chen et al.’s (2018) report could explain why over 90% of the current study participants expressed interest in experiencing active teaching strategies and learning like frequent case studies, simulation, group discussions with their culturally diverse colleagues who can share their perspectives on how to handle ICC challenges, clinical and community rotations with culturally diverse populations as the focus. According to participants, there is a need to revise teaching strategies used to teach cultural components within their nursing curricula. Majority of their nursing faculty members use traditional lecture, videos or pre-class readings to pass their message across. However, Eison (2010) and Tanner (2009) proposed the use of

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active student-centered teaching strategies, instead of traditional lectures, to promote learning, retention, and application of information. In this study, participants emphasized that their nurse educators occasionally incorporate case studies, group discussions, and guest interviews on residential schools and Aboriginal culture which are mostly related to social justice and not communication. Few participants indicated that they encountered ICC in simulation; however, the content was perceived as being inadequate to equip them with skills needed for clinical ICC encounters. Bahreman and Swoboda (2016) expanded on the need for competent communication skills when addressing culturally diverse clients. The authors further explained creative teaching ways of incorporating cultural communication skills in simulation; this includes scenarios where nursing students care for real culturally diverse clients during simulation sessions.

Other proposed teaching strategies by participants included having culturally diverse guest lecturers, role play, simulation with real people from culturally diverse backgrounds, involvement in transcultural research and experiential workshops. Townsend (2018) found online role-playing as an effective teaching strategy. Another suggestion was the commencement of a mentorship program where nursing students will be paired with a culturally diverse faculty or colleague. By interacting among themselves, participants believe they will build ICC knowledge and communication skills. The finding on mentorship is consistent with results of studies of Koskinen and Tossavainen (2003) and Mills et al. (2014). Koskinen and Tossavainen (2003) found that student nurses adjusted and learned better and when they were paired with a named cultural mentor or tutor at their home college as compared to during a cultural exchange program. Meanwhile, Mills et al. (2014), reported how mentorship circles boosted the confidence, reflective thinking ability, emotional intelligence,

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and the communication skills of their participants. Mentorship in nursing has unprecedented successes (Crow, Conger, & Knoki-Wilson, 2011; Dennison, 2010; Kostovich & Thurn, 2013), and must be considered to enhance ICC education. Some of these proposed interventions may be costly and time-consuming. Chen et al. (2018) propose that further research is needed to identify cost-effective teaching and learning strategies that will integrate the concept of cultural encounters and cultural knowledge to increase students' exposures to culturally diverse populations.

Several authors have indicated that cultural encounters are central to the acquisition of cultural competence, cultural skills, cultural awareness, and cultural knowledge, and the development of confidence to deliver care to culturally diverse populations (Duke et al., 2009; Long, 2012; Shen, 2014). However, the current study participants reported that they had limited opportunities to care for culturally diverse clients during their clinical practicum. They shared that Clinical Education Facilitators (CEFs) rarely paired them with people from different cultures. Most CEFs focused on disease-specific cases of clients instead of their cultural background during patients' assignment. This pattern of patient allocation was perceived to contribute to nursing students inexperienced in their interaction with culturally diverse clients. Participants also perceived that CEFs may lack ICC skills. They further recommend that the CEFs acquire knowledge and skills related to ICC and cultural safety. This finding is similar to those of other studies which highlight that nurse educators may need more knowledge preparation to deliver a culturally competent or culturally safe curriculum (Kennedy, Fisher, Fontaine, & Martin-Holland, 2008; Lipson & Desantis, 2007; Rowan et al., 2013).

Participants shared variable sources of ICC knowledge which has prepared them for future nursing practice with culturally diverse clients. These sources included: nursing course,

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extracurricular activities (individual course work), travels, participant's cultural background and upbringing, and personal socialization. Pacquiao (2007) posited that an encounter with diversity education can influence the attitudes of health care professions, including nurses. It was interesting when participants compared their ICC knowledge in terms of their nursing education program and their own experiences outside nursing. They reported that they gained more information and skills through traveling, being with friends and families, and their environment and not necessarily from the nursing curriculum. This finding is inconsistent with results of Kourkouta and Papathanasiou (2014) and Plaza del Pino, Soriano and Higginbottom (2013). Kourkouta and Papathanasiou proposed that engaging nurses in best expertise training and continuing education about the proper technique of communication will enable them to respond sufficiently and humanely to the expectations of their clients. Their report suggests that nurse educators need to explore factors that contribute to effective ICC. Likewise, Plaza del Pino et al. (2013) reported that one must personally encounter culturally diverse clients in different health and disease states to gain knowledge in interacting with them. However, the same finding from the current study is consistent with the study results of Yakar and Alpar (2018). Yakar and Alpar found that 47.5% of nurses obtained cultural knowledge from previous experiences and 41.7% from friends. Several authors also report on how personal values and one's cultural background could influence communication (Fall et al., 2013; Jonasson & Laurant, 2012; Okech et al., 2015; Oliveira, 2013; Stadler, 2013). The different schools of thought provided on this finding requests further research to ascertain what specific factors promote ICC knowledge.

Participants who identified as immigrants felt they could engage in ICC better than their colleagues who are whites because of their heterogeneous cultural background,

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upbringing, and cultural immersions experiences. Caring is one of the basics of nursing education and nurse educators must ensure that they incorporate adequate cultural content in nursing curricula to build on the knowledge skills and abilities of student nurses to be able to adequately care for culturally diverse individuals and populations (Waite & Calamaro, 2010).

Dais, Clarke, and Gatua (2016) found that the concepts of cultural competence and diversity are often not well integrated into nursing curricula. This report is reflective of participant response, as they feel that they had limited content off ICC in their nursing program. Thus, the findings of this study reveal a potential need to revise nursing curricula. One participant wished ICC was an actual stand-alone course integrated into nursing curricula. The participant, thus, wants an entire course syllabus to be allocated and designed to impart ICC related knowledge and skills to nursing students within the nursing program. There is a congruent analysis of this finding with the findings of Stiles, Schuessler, and James (2018). Their study found that stand-alone courses on culture have a more positive transcultural-self-efficacy impact on graduating nursing students than embedded course work. These imply that students can reflect on the critical concepts addressed within those courses and effectively apply the knowledge received to clinical situations.

Other participants recommended that content on culture and ICC in nursing curriculum must be more generalized and diverse instead of solely focusing on Aboriginal people's experiences. This recommendation may be consistent with studies of Crotty and Doody (2016) and Calvillo et al. (2009). Crotty and Doody stressed that communication skills are essential in health delivery and thus, cultural models must be incorporated in education to build transcultural care competencies when caring for people within a diverse population, including those with disabilities. Cultural models do not focus on specific people but different

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population groups to achieve the intended effects. Calvillo and colleagues (2009) explained that current curricular models usually do not meet the needs of nurses who encounter diverse patients in varied clinical settings. It is imperative to revise curricula to incorporate strategies that will enhance the acquisition of knowledge, skills, and attitudes that makes one competent in a cultural domain. Ideally, participants proposed that another course is set up to feature ICC and that all nursing courses should be able to instill a culturally safe care mindset for future nurses.

Several authors proposed ways of integrating intercultural nursing aspects into nursing curricula to enrich students' knowledge and experiences suitable for interactions with culturally diverse populations (Bohman & Borglin, 2014; Carlson et al., 2017; Rowan et al., 2013; Wächter, 2003). Effective ICC requires cultural humility, respecting the differences between cultures, and incorporating self-questioning, cultural immersion, active listening, and negotiation in one's communication with patients from diverse cultures (Chang et al., 2012). These skills promote self-reflection and various interactions and must be taught as part of nursing programs to equip nurse graduates with those communication skills. There could be other strategies like student exchange programs (Bohman & Borglin, 2014) and cultural immersion programs (Mkandawire-Valhmu & Doehring, 2012). According to Mkandawire-Valhmu & Doehring (2012), cultural immersion programs have the capability of making students open to strengths or positives within a culture and can influence their perception of other cultures and nursing practices. Wachter (2003) describes how students can be made to develop international and intercultural skills by integrating intercultural and international dimensions into curriculum and learning activities.

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Diversity among nursing students is a challenge to nursing faculty as they need to consider the various learning needs of their ethnically and culturally diverse student groups (Ackerman-Barger & Hummel, 2015; Davidhizar & Shearer, 2005). It is noteworthy that participants perceived that faculty were homogeneous (Caucasian women) which could negatively influence teaching and clinical exposures and facilitates culturally safe practices. They expressed the desire to have a culturally diverse faculty with variable instruction and cultural perspectives and experiences instead of the all-Caucasian faculty membership. Zajac (2011) supports the recruitment and retention of minority nurse faculty to meet the needs of the culturally diverse student populace.

Additionally, participants perceived that faculty who lecture on cultural components and transcultural nursing care fail to incorporate active teaching and learning strategies which could make them think critically and apply concepts from their theoretical knowledge. This finding is inconsistent with how several authors perceive the role of nurse educators and CEFs regarding transcultural nursing and communication (Arieli, 2013; Campinha-Bacote, 2007; Escallier et al., 2011; Henderson et al., 2016; Olson, 2012). According to them, nurse educators and CEFs have been made to understand the essentiality of preparing the nursing students to communicate competently with their culturally diverse patients and interdisciplinary health teams. Montenery and colleagues (2013) assert that nurse educators are capable of role-modeling future nurses regarding the process of cultural communication competence. Hence, they need to be educated on the theoretical perspectives and desired outcomes of transcultural nursing and strategies to teach their students (Leininger, 1995; McMillan, 2012; Sealey, Burnett, & Johnson, 2006; Ume-Nwagbo, 2012). The converse may be true if the nurse educators lack cultural desire and are reluctant to engage in the process of promoting culturally

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congruent care. Students may, therefore, lack the cultural skills and cultural desire which may negatively impact client care. There is a need to develop best strategies that will guide the nursing faculty to integrate best teaching strategies to support these students (Davidhizar & Shearer, 2005).

According to participants, caring for culturally diverse clients as a nursing student can be difficult amidst institutional barriers like low staff-patient ratio, lack of professional interpreters, and time constraints. Duke et al. (2009) also expressed how structural constraints like time limited their participants from in-depth health assessments and the provision of good quality care to the clients. They pointed out how interacting with clients in another language took most of their time, making routine nursing care for all scheduled clients even difficult. The finding on interpreters is consistent with results from the study of Bischoff et al. (2003), who highlights the institutional barriers to communication between nurses and culturally diverse clients and how it affects health assessments, diagnosis and health outcomes. According to them, institutions may not have the financial capabilities and may result to ad hoc interpreters (relatives or unprofessional interpreters) or bilingual nurses.

The current study participants reported that some family members of their clients had to be engaged in the act of interpreting health care proceedings because of the absence of a professional interpreter at the unit. This finding is consistent with studies of Karliner et al. (2007) and Van Rosse et al. (2016). Karliner et al. (2007) asserted that a language barrier could be a threat to the quality of hospital care which can affect patient safety and cultural safety, especially when the communicators speak different languages. Van Rosse and colleagues also explained how some care providers assume that getting a translator is the patient's responsibility; hence they engage their families and the patients in the process. This practice

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could facilitate misinformation as the translation may not be exact. These cultural mediations lead to problematic communication since their deficient translation and composure may lead to misunderstandings, false interpretations, and or low compliance with health care routines. Bischoff (2003) further reported that when the subjective quality of communication was good or sufficient, symptom detection was significantly higher and vice versa. Other authors reported on the adverse effects of a language barrier between nurses and clients (Karliner et al., 2007, 2010; Suurmond et al., 2010; Van Rosse et al., 2016; Wasserman et al., 2014). There is a call on health care agencies to consider communication essential in the delivery of care, professional education, service planning, staff deployment, recruitment, and continuing education. There is also a need to hire trained interpreters to make the work of nurses less cumbersome when interacting with culturally diverse clients.

Lee, Sullivan, and Lansbury (2006) shared that they interacted with their clients using non-verbal cues or simple English. Some of their clients could not speak English, and so they utilized body languages to either ask questions or respond to them. The authors believe the non-verbal gestures could be misinterpreted. This is like the findings shared in the current study. Participants indicated that culturally diverse clients used body language to communicate their symptoms and how they want to be cared for. Nurses should be careful with their choice of word, accent, and non-verbal gestures when interacting with them. The words of those with accents are sometimes incomprehensible, so there was a need to listen to them attentively. This similar finding implies that student nurses must be vigilant and skillful in interpreting non-verbal cues of their clients.

Participants also reported other barriers which limited their ICC encounters during their practicum; clients' cultural beliefs, values, and preferences, gender roles, and cultural

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assumptions made by senior staff. Unfortunately, they ended up becoming more anxious as they were not adequately prepared psychologically to deal with the situation. However, participants were open and willing to adjust their care delivery to meet client's needs which made them learn from these experiences. Those participants who were not familiar with the traditions and preferences of their clients asked questions to dispel their stereotypical views. This finding is consistent with that of the Aboriginal Nurses Association of Canada, Canadian Associations of Schools of Nursing, and Canadian Nursing Association (ANAC et al., 2009) who stated that nursing students might have preconceived thoughts about Indigenous people and other vulnerable populations like immigrants and refugees. Indigenous knowledge and knowledge of different cultures within nursing curricula can dispel any stereotypical or essentialist perspectives for culturally diverse clients (Dion Stout, 2012). Rowan et al. (2013) in their study, reported how some of their participants used Aboriginal population as the primary focus for cultural integration while some considered other multicultural groups.

Notwithstanding, participants shared that factors such as having some knowledge of different cultures, experiential learning experiences, and ingrained attributes learned from their nursing program could promote ICC. Other facilitators such as better staffing on their allocated healthcare units, adequate time to adapt to caring for culturally diverse clients, one's cultural background, being paired with a good buddy nurse, and being friendly and observant contributed to building their ICC skills and knowledge. According to participants, no stand-alone factor could equip them. All these contributing factors were inter-related. Some of the ingrained nursing attributes and values were patient-centered care, compassion, respect and caring. These facilitators enable participants to witness positive impacts on their nursing care with culturally diverse clients.

Students' Perceptions of the Impact of ICC Education on their Ability to Care for Culturally Diverse Clients

This section discusses answers to the second research question: "How has exposure to ICC in the nursing curricula impacted undergraduate nursing students' abilities to care for culturally diverse patients, families, and communities?" The inclusion of ICC content in the nursing curriculum was beneficial and made participants more empathetic, and more open to elicit information and plan culturally safe care for culturally diverse clients. This section adds to the literature by highlighting the key benefits students derived from studying ICC in their nursing program.

Perceived benefits of engaging in ICC. Few participants who benefited from the ICC content and experiences spoke to the importance of having ICC in the nursing curriculum. They found that it increased their level of cultural awareness and interactions with culturally diverse clients. They reported on how it increased their desire to be open and render patient-centered care based on the client's cultural preferences, and this made their clients exhibit better health outcomes and satisfaction with services.

Polly and Nicole (2011) recommend that only clinically relevant questions must be asked of culturally diverse clients. However, there seem to be a paucity of literature on the best strategies to ask culture-specific questions that can help plan the care of culturally diverse patient populations. According to participants, knowing what to do, say or questions to ask when interacting with culturally diverse clients saves time during an assessment, enhances individualized care planning and implementation and speeds up medical decisions among the health team. Interestingly, participants feel that ICC goes beyond theory or asking certain

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specific questions during assessments. They indicated that one must think of how to present the questions across different people while considering their culture and way of understanding issues. As well, we must carefully consider how we incorporate that information in their plan of care. They also shared that ICC further builds a trusting relationship between the nurse and the culturally diverse client and improve patient outcomes. Questions that helped them were “what do I need to know about you to provide you with the best care?” and “Is there something that you want me to do differently?”

Participants expressed that they were motivated to care for their culturally diverse clients in a culturally safe way. Quality care is evident when providers exhibit good communication with their clients (WHO, 2019b). The World Health Organization iterates that culturally diverse clients and their families have the right to know what is happening to them, what to expect and possible health outcomes irrespective of their language, gender, race, or beliefs. Thus, ICC competence is necessary to enhance the quality of care to culturally diverse populations. WHO proposes that the health care services ensure that quality of care is provided to individuals and patient communities by focusing on being “safe, effective, timely, efficient, equitable and people-centered” to improve desired health outcomes (WHO, 2019b).

Through these experiences, about 60 percent of participants expressed that they currently see healthcare delivery differently. They have become more accepting of other cultures, more open to learning and they now see the need to plan individualized and culturally safe patient care. This finding is similar to that of Duke et al. (2009) who explained how nurses or students learn to open up, perceive cultural differences, and create a common ground to build a relationship with their client to foster effective communication. Study participants further expressed that they believe healthcare delivery must not be based solely on biomedical models,

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but rather other factors like culture must be considered to promote holistic healthcare delivery. This consideration might be because most clients have their own health beliefs or worldviews and may misunderstand the bio-medical perspective of the nurse (Olt et al., 2010). Thus, the student nurse must be cognizant of these cultural influences on health- disease processes so they can learn how to communicate effectively to avoid misunderstanding and miscommunications (Leininger, 2002; Tuohy, 2019). Additionally, they would consider client preferences over theirs and provide care that goes beyond compassionate care.

Another significant impact of ICC on healthcare delivery was the awakening desire for cultural empathy among participants. Participants shared that they feel at ease communicating with their clients as they understand clients' perspectives better, and are willing to make the client feel valued, heard, and safe. Exposure to ICC was perceived to enhance participants' curiosity, patience, motivation, confidence, and global attitude. This finding may be indirectly related to the virtue of human love proposed by Hemberg and Vilander (2017). Hemberg and Vilander assert that human love is the foundation for every caring relationship between health providers and their clients, irrespective of their culture and language. They believed everyone could make love evident through an act of compassion, respect, kindness, impartiality and by creating time and space for an encounter. However, when human love is visible, one can have compassion, empathy, and consider avenues that they could adjust their care and make clients feel comfortable in their conversations.

Findings revealed that participants are eager to engage in activities that will provide culturally congruent and culturally appropriate care to culturally diverse clients because of the 'cultural safety' content in their curricula. They shared that cultural safety is a key factor to consider when interacting with people from culturally diverse backgrounds. One must

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acknowledge and do away with prejudices, stereotypes and personal biases to engage in culturally safe interactions. They also expressed that the recipient must define culturally safe care as to whether their cultural dispositions are taken into consideration during the delivery of care. The above-mentioned findings are consistent with studies of authors such as the ANAC et al. (2009), Nursing Council of New Zealand (2011, p. 7), and the University of Ottawa website (2018). Participants believe that eventually, culturally safe nursing care may lead to patient-centered care as the patient is the center of the plan of care. According to participants, culturally safe nursing practices can promote the trust of clients for nurses and the health care system. Such actions can promote healthcare accessibility and health equity. They encourage actions like being open and observant, self-reflective of one's actions, seeking clarification from the client when in doubt, and adjusting one's attitude to accommodate preferences of clients to health service delivery. These actions are similar to findings of Brown et al. (2016) and Cioffi (2003). According to participants, every individual is different and has the right to be cared for according to their cultural preferences to promote patient safety (McPherson, 2016). This finding reflects the recommendation by WHO on the provision of quality care that considers the preferences and aspirations of individual service users and the culture of their community (WHO, 2019b).

Patient safety, which is the reduction and mitigation of unsafe acts and the increased use of best practices leading to an optimal patient outcome, was desired by some participants (WHO, 2009). However, factors such as language barriers and lack of confidence to have an interaction with culturally diverse clients have been reported to pose a risk to health assessment, misdiagnosis, and poor patient care planning (de Moissac, & Bowen, 2018). Such negative factors may reduce the quality of care given to clients from all backgrounds. Most participants

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did not directly associate medical errors or unsafe nursing/medical practice with problematic intercultural communication. Future studies could more explicitly explore nursing students' understandings of the relationships between poor intercultural communication and medical errors of incidents. Future intervention studies could explore the association between effective intercultural communication and quality patient outcomes.

When culturally diverse clients recognize the respectful dialogues, as well as the equitable, safe, and quality of care provided to them, irrespective of their culture, and inherent power difference, it is believed that the goal of cultural safety will be reached (CNA, 2010; First Nation Health Authority of British Columbia, 2016, p.5). Most participants who had ICC encounters shared that they cared for newcomers, immigrants, and Aboriginal people. Of this population, they faced difficulties with language, gender, and type of socialization (visitors). This finding is similar to the study of McClimens, Brewster, and Lewis (2013) who found that nursing students expressed difficulties and challenges meeting the cultural needs of patients, with a particular focus on issues related to language, food, and gender. These challenges call for immediate actions to engage nursing students in knowing the critical information to observe and probe for when interacting with a culturally diverse client. Addressing challenging areas can be the first option. According to the University of Ottawa website (2018), it is necessary to acknowledge culture as a determinant of health, know the issues one is expected to encounter in cultural communications, as well as the various types of culture, to engage in effective ICC. Blanchet and Pepin (2015a) recommend teaching cultural constructivism over cultural essentialism.

To achieve this feat, about 40% of the participants shared that most admission health assessment forms have no cultural item on it, so they suggested that authorities responsible for

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changing hospital protocols act to revise health assessment records so that nurses can probe more to know one's culture and their preference for care delivery during the period of hospitalization. Additionally, they stressed on the need for interprofessional or inter-faculty collaboration to educate future health professionals on ICC which is essential for their practice and health team decision making. Nurse graduates and nurse educators could engage in professional development programs to upgrade their knowledge and skills on ICC over the years which will enable them to adapt to caring practices and communicating with culturally diverse populations.

Based on their experiences, participants advised that communicating effectively with culturally diverse clients require observing verbal and non-verbal cues and using simple language that is understandable by both parties. Likewise, one size does not fit all; hence nurses must bear in mind that every client is unique even between similar cultures and must be provided with individualized respectful care.

The conceptual model. Although the IMICC model proposes that education or experience facilitate a global attitude and motivation to interact with culturally diverse clients, some participants reported feeling uncomfortable to retrieve some vital information from culturally diverse clients. For example, some participants shared that they were uncomfortable asking for treaty numbers from clients with First Nation ancestry. Participants were awkward asking certain culture-specific questions from their clients. Participants who were of Aboriginal ancestry also experienced stereotypical attitudes from patients, which decreased their desire to approach culturally diverse clients. This finding is consistent with the findings of authors of the model during the model testing (Arasaratnam et al., 2010). They had lower mean score value of 2.41 out of a total of score of 7; where 7 agreed with the concepts impacting their interaction

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with culturally diverse groups. This finding implies that education and experience may not be enough. Further research may be conducted to examine factors that can facilitate one's confidence in approaching and asking culturally-specific questions during an intercultural interaction.

Interestingly, participants indicated that ICC becomes more comfortable when one has empathy and is ready to actively listen to, understand, and accept their client's views. This finding is consistent with Arasaratnam et al. (2010), as both education and empathy were external variables that had an influence on the other components of the model leading to intercultural communication competency. Moreover, empathy received a greater mean score during the model testing. But for this study, only education or experience were considered. This finding, therefore, implies that nurse educators have a role to play in impacting the ability and skills needed for students to empathize with culturally diverse clients.

Proposed nursing ICC model. The current study highlighted key factors that influenced the process required for gaining ICC skills and abilities besides what Arasaratnam and Doerful proposed in the IMICC framework. The figure below provides a summary of the elements of the proposed model (**figure 9**).

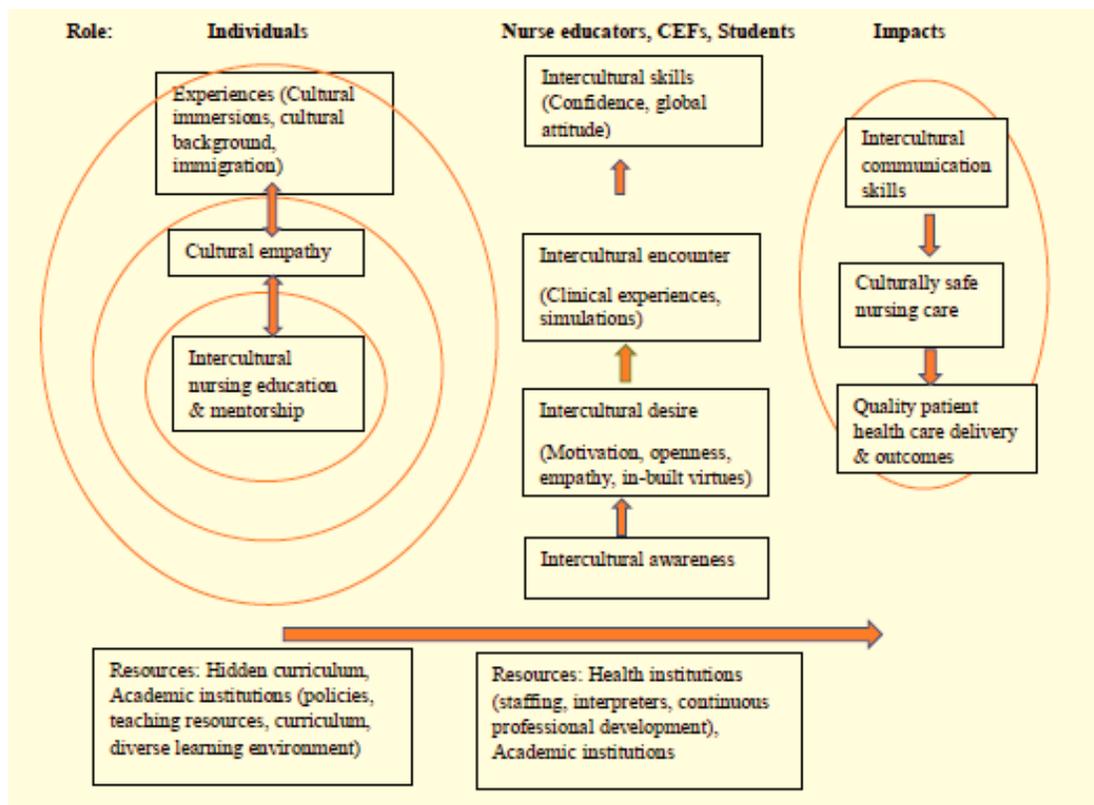


Figure 9. Proposed Nursing ICC model

Strengths and Limitations of the Study

A strength of this study was that different data sources were used to ensure data triangulation. An additional strength was its use of a tested model to guide data collection and analysis. The overarching theme “one size does not fit all” was derived from the raw data.

However, there were a few limitations. The sample consisted of young adult females with limited ICC experiences. Another potential limitation will be the single site setting used for the study which may limit the generalization of the study findings. The participants may have expressed interest in ICC within their nursing program and may have culturally diverse

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background experiences. However, these nursing students may not be representative of all nursing students who were expected to share their perspective of ICC in their nursing program. Moreover, these findings are based only on students' perceived views. Faculty perspectives, use of evaluative self-efficacy tools, and patient outcomes (satisfaction levels of care) may be needed to validate some of the responses.

Additionally, the research design may be a limitation. Perhaps a mixed method design comprising quantitative, observations, and interviews could have better informed us of the self-efficacy of undergraduate nursing students' ability to engage in intercultural communication during simulation, clinical practicum, and lectures. A mixed method research design could have provided much information to compare perceptions on ICC course content as well. Further research is needed to address these gaps.

Study Implications

Practical implication for nursing academia. There is a growing need for culturally congruent care and effective ICC. All participants believed ICC is essential and necessary in their nursing program and future practice. The onus lies with leaders in nursing academia to recognize the value of educating students about ICC and equip faculty with the knowledge and skills required for effective teaching on ICC. The faculty is tasked with the revision of curricula and using more captivating and problem-solving strategies to provide students with the requisite skills and knowledge for effective ICC.

Moreover, it is evident from participants' responses that one cannot know every culture or how to communicate with everyone and assumptions can be barriers to ICC. However, nurse educators must seek commonalities or an effective approach to address this

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irrespective of one's culture. It will be better to establish this approach from a constructivist perspective as proposed by Blanchet and Pepin (2015a).

Empathy was identified as a significant virtue that facilitated ICC between nursing students and their clients. This information implies that strategic measures must be taken by nurse educators to build the knowledge, desire, and skills of cultural empathy in student nurses to enable them to facilitate effective ICC with their clients.

Practical implications for practicing nurses and health institutions. Relational practice is vital in nursing and healthcare delivery, and this begins with communication. Authors such as Johnstone, Hutchinson, Rawson, and Redley (2016) and Brooks, Bloomer, and Manias (2018) report the increasing demand for nurses to engage in intercultural or culturally sensitive communications. Stansfield and Brown (2013) assert that nursing focuses more on individualistic perspectives as compared to a broader contextual perspective in relational practice. They proposed that relational practice and epistemologies must include a holistic focus which integrates all aspect of physical health, emotional and spiritual aspects; people's historical, economic, social, cultural, and family contexts; and issues of identity and self-determination. It is essential that practicing nurses get to know that every individual client is different and acknowledging their cultural background in our assessments and plan of care can go a long way to improve the nurse-client relationship and health outcomes. Another item to enforce this relational practice is cultural empathy. It is, therefore, necessary that all nurses acquire some level of cultural knowledge, cultural empathy, and gain skills to address culturally diverse clients holistically in their communication. Diversity matters a great deal in quality nursing practice. Participants recommended that nurses in the profession undertake professional

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development courses to develop these communication competencies to enhance nurse-patient relationships.

The lack of culture-specific questions on the health assessment form is another issue that must be addressed. The inclusion of a cultural component in the health assessment process is necessary to provide nurses ideas on the right culture-related questions to ask for better responses. Another area needing consideration is the effective distribution of workforce to compliment nurse-patient ratios and efficient delivery of health care services. Institutions need to put in the appropriate measures and policies to support ICC education and usage.

Implication for research. I was only able to locate a small number of studies on ICC in nursing. Not much research has been done in nursing education which warrants the need to explore the field of ICC among nursing students and nurse educators. The findings related to insufficient content, personal and cultural experiences, inadequate clinical contacts and teaching strategies for ICC are of particular concern since they influence the use and impact of ICC. Further research is needed to address such concerns among students and educators.

Conclusion

As Canada and other countries in the world becomes more and more culturally diverse, nurses are faced with the challenge of being equipped with skills and abilities to interact with their culturally diverse clients. There is a growing body of evidence iterating the need for ICC or culturally safe care. However, there is a continuous gap in the literature on ICC in nursing programs or the perspectives of the nursing student on ICC. This study is the first, if not among the very the few, qualitative study to delve into perceptions of ICC among nursing students.

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This study adds to the literature by shedding more light on the perceptions of student nurses on ICC in their nursing program.

ICC begins during the initial health assessment and continues throughout the period of hospitalization. The concept of culture and communication are introduced to student nurses as this is part of their entry-level requirement and the knowledge is expected to be updated throughout nursing practice. However, some students express that the content of ICC is not enough in their nursing curricula. It was interesting to note the role of participants' personal experiences with ICC complimented their nursing education to boost ICC skills. Nursing faculty and institutions have a significant role to play to maximize the impact of intercultural nursing education among undergraduate students. Nursing faculty must equip themselves with culturally competent, culturally sensitive, and culturally safe knowledge and skills which is transferrable to their students. They must also find appropriate teaching and learning pedagogies and methods to introduce intercultural expertise to students. Current literature is still deficient of the proper ways to incorporate ICC in nursing curricula. Most literature focus on cultural awareness and cultural competence. More research is needed to be conducted on faculty perspectives of ICC in nursing programs as well as innovative ways to incorporate the concept to maximize its impact on undergraduate nursing students. In furtherance to that, health institutions must adopt policies that will include a cultural component on health assessment records to expedite the acquisition of more cultural information from patients during their interaction with a student or graduate nurses. These will further improve nursing care planning and health outcomes.

This study will advance nursing knowledge by promoting the understanding of ICC in nursing education programs and an understanding of students' opinions of their development of

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ICC competence. The use of reflection has the potential of engaging both students and faculty to look back on course content, teaching and learning pedagogies and/or methods which can better impact nursing education and health care delivery of the future health workforce in culturally diverse contexts. This study was significant in identifying the barriers and facilitators of ICC in undergraduate nursing education programs. It also provided an understanding of the perspectives of nursing students on their ICC experiences and the benefit of ICC education towards their future professional nursing practice. Furthermore, it can assist faculty to identify the ICC educational needs of student nurses, the gaps in curriculum, and the expectations of students and clinical practice.

The findings support the IMCC model as experience or education impacts other components such as motivation, interaction involvement, global attitude. However, the position of empathy in the model needs to be redefined to enhance its applicability in nursing practice. Although participants did not yet report being competent with ICC, we expect that continuous encounter and practice will improve their skills. Duke et al. (2009) indicated that competence could develop when one challenges prior knowledge and generates new knowledge logically through iterative cycling of reflection and action. Effective ICC can improve culturally safe nursing practice yielding innumerable benefits.

Recommendations

This study is significant in informing health care workforce literature, curricula, clinical placements of undergraduate students in health care professions, diversity inclusion/ learning environments, and intercultural communication policy. Based upon the study's findings, these recommendations were made:

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Proposed teaching strategies. Incorporation of active teaching and learning strategies based on effective cultural models is recommended. The use of diverse teaching strategies will help address the learning needs of different student populations. It is vital to know the learning needs of your class and introduce a variety of teaching strategies to maximize impact. Findings revealed that some nurse educators create awareness of different cultural groups but provide limited exemplars to guide practice. This finding implies that there is a need to go beyond awareness creation to implementation/ skills adaptation/ influencing clinical judgment when dealing with diverse cultures. In this view, we further recommend the production of ICC case study exemplars based on ICC and cultural models to guide and facilitate ICC experiences among students with the health profession.

Curricula revisions. Curriculum revisions are required to incorporate more content on and activities for ICC. In collaboration with study participants, we propose that ICC should be taught as a stand-alone course or embedded in other nursing courses. Those integrated courses should be allowed enough time for content delivery. Stansfield and Browne (2013) reports that when students gain Indigenous knowledge and their approaches to health and healing, they become reflective of their role within the complex set of relations, which promotes a nursing practice that is more inclusive and accepting of perceived individual and cultural differences, as well as the effective management of the power dynamics in a relationship. However, we also suggest that other cultures, especially those of immigrant populations, are considered when planning lessons. This consideration will help advance nursing knowledge to be all-inclusive.

Clinical placements. It would be beneficial to provide CEFs with the direction to consider cultural factors when allocating a client to a student nurse and not merely consider

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disease conditions. The CEFs must be well educated and experienced with culturally congruent nursing care so that they can address any clinical situations that may arise.

Learning environment. We propose the promotion of an adequate level of diversity inclusion in the students and faculty populace within the learning environment. This suggestion implies that there should be an enrollment of students who have different cultural backgrounds to enrich the diversity of thoughts and actions among the student populace (Carlton et al., 2007). Likewise, academic nursing institutions must do well to hire culturally diverse faculty who will share different clinical experiences, theoretical and cultural perspectives to better equip students for effect encounters with their culturally diverse clients. Access to culturally diverse faculty can boost student confidence in approaching other different populations.

Nurse educators. Continuous professional development for nurse educators on cultural communication is recommended. A limited number of nurse educators have taken transcultural nursing or hold international transcultural nursing certificates (Montenery et al., 2013). According to Montenery and colleagues, an immersion in diverse cultures enhances self-reflection of personal views, beliefs, and biases. Some authors recommend faculty development on transcultural nursing competence which includes intercultural communication (McMillan, 2012; Sealey et al., 2006). When nurse educators gain knowledge on cultural diversity and cultural communication, for instance, those embedded in Indigenous knowledges, they can reflect, analyze and re-evaluate pedagogical approaches to link theoretical perspectives of health to community perspective to integrate the concept of cultural diversity inclusion in patient care within nursing curricula (Stansfield & Browne, 2013). They may also develop value for diversity and related concepts. Nursing faculty is encouraged to upgrade their cultural diversity skills to be able to impact culturally safe knowledge and skills unto students.

Interprofessional or inter-health faculty collaboration. Furthermore, the findings indicate that all health faculties come together to draw strategic measures which build teamwork towards ICC competencies of health professional students.

Further research. There is a dearth of literature on the cultural competency of faculty (Montenery et al., 2013). Hence, we propose that the perspectives of faculty on ICC must be sought to know their views on ICC in nursing curricula, their fears, and challenges and any intervention that will be of benefit to other institutions. Moreover, there seem to be paucity of literature on specific intercultural communication models specific to nursing; although some of the transcultural models (Giger and Davidhizar Transcultural Assessment Model, Leininger Sunrise Model, Purnell Model for Cultural Competence) have a communication concept, it is not well defined in its process of achieving ICC competence. We, therefore, propose that a systematic review of literature is done to know useful concepts that can translate into a nursing care model for ICC in nursing programs. There is a need also to evaluate the integration of the proposed model as well as assess the efficacy of intercultural communication care models within the nursing programs.

Health care institutions and health system reforms. Health agencies must be able to provide adequate resources to support their nursing staff in their communication with clients from culturally diverse backgrounds. For instance, the use of a professional interpreter should be encouraged, how and when to consult interpreters and who pays for the interpreter must be clearly stated. Van Rosse et al. (2016) suggested that the hospital pays them. Ward nurse managers must relay such information to their nursing staff for effective executions during times of awkward interaction with their culturally diverse clients. Nurses may not get the chance to use interpreters for all their routine care but getting the right information during

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nursing assessment and patient education or discharge session is essential for better health outcomes.

Hospitals may add a section on their health assessment record to report language barriers as proposed by the Joint Commission International (JCI) Accreditation Standards for Hospitals (JCI, 2014). Additionally, hospitals may add a section on the health assessment record which probes into one's culture and their preference for nursing care. These cultural components will guide care planning as well as discharge and follow up care.

Health care policy. It would be beneficial to encourage various institutions, including healthcare, to adopt cultural communication by-laws in their institutions. These may include diversity inclusion statements, accepted languages, and the number of languages eligible for interpreters, and among others. Indigenous populations should have the right to use some of their languages in health care delivery, especially in Indigenous communities, as was done when the Sami Act of 1987 was released for the Indigenous people of Norway (Koukkanen, 2005). Taking into consideration, the fact that patients have the legal right to make informed decisions among several patient rights means that there may be implications for communication in health care delivery. The comparative overview of the Patient Bill of Right by Smith (2002) did not highlight any concerns for intercultural or multicultural communication. There is a need to revisit the Canadian Bill of right and address the content of multiculturalism. This action, we believe, may have an influence on other health institutions to change their policies to enhance health care provider - culturally diverse client communication and relationships. Moreover, the TRC calls to action recommends that the federal government acknowledge that Aboriginal rights include Aboriginal language rights (TRCC, 2015, p. 204).

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In furtherance with the above, we also suggest the strengthening of other communication by-laws by nursing regulatory and accreditation bodies on the requirements for entry-level practice (DeSantis & Lipson, 2007). Nursing regulatory bodies should stress on the integration of intercultural communication as part of transcultural nursing education. This move can influence academic institutions and nurse educators to put in the necessary measures to see the implementation of ICC in nursing curricula.

Chapter Summary

This chapter provided a detailed discussion of the findings. Related literature was compared to determine which findings were either consistent or inconsistent with current literature regarding the two research questions for the study. I further analysed the conceptual model with study findings and proposed a new model for further development. The chapter explains the implications of the study for academia, nursing practice and further research, and provides the strength and limitation of the study. The chapter ends with a conclusion of lessons drawn from the discussion and recommendations for additional interventions provided.

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Appendix A: Empirical Evidence on ICC in Nursing Education

Table 1. Journals Reviewed

Author	Title	Year/ Type of Literature	Study Design/Sample Size/ Aim	Summary of Findings
Philip, S., Manias, E., & Woodward-Kron, R.	Nursing educator perspectives of overseas qualified nurses' intercultural clinical communication: barriers, enablers and engagement strategies	2015 (Journal Article)	Qualitative, exploratory research design using semi-structured inter-views N= 12 Nurse Educators	Pointed to the domains and causes of communication challenges facing overseas qualified nurses in new healthcare settings as well as strategies that the nurse educators and nurses can adopt. Communication cannot be merely regarded as a skill that can be taught in a didactic programme. Comprehensive understanding is needed about the sociocultural dimensions of these nurses' orientation, which can impact on how they communicate in their new healthcare settings.
Yu Xu, & Ruth Davidhizar	Intercultural Communication in Nursing Education: When Asian Students and American Faculty Converge	2005 (Journal)	The meanings of various verbal and nonverbal behaviors of Asian students are examined to clarify their communication patterns.	Culture-based assumptions are identified, and measures to improve intercultural communication in nursing education are provided.
Arasaratnam, L.	Intercultural spaces and communication within: An explication	2012 (Journal)	Literature review Aim: To explicate the nature of intercultural spaces and how they relate to intercultural communication by unpacking Arasaratnam's definition of intercultural spaces	Intercultural spaces are occupied by people who belong to different thought communities and intercultural spaces necessitate a measure of mindfulness from those who operate within. It has also been noted that, when operating in intercultural spaces, one is confronted with one's implicit assumptions and possibly some concepts that one has reified. The extent to which one is competent in navigating

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				intercultural spaces is reflected in one's ability to be cognisant of the subjective nature of one's own thought community. Conceptualising 'cultural' differences in terms of differences in thought communities rather than differences in 'race' or 'ethnicity' enables us to understand intercultural communication in a broader manner, allowing for multiple variations in instances in which interpersonal communication becomes intercultural communication.
Qin, X.	Exploring the Impact of Culture in Five Communicative Elements - Case of Intercultural Misunderstandings between Chinese and American	2014 (Journal)	Literature review Aim: In light of performance theory, a five-element model is proposed as a practical tool to analyze how cultural differences lead to misunderstandings	Supported by cases of misunderstanding in Chinese-American communication, this model shows that five key elements in intercultural communication: roles, place, time, audience, and scripts, are all involved in the construction of meaning and each of the elements has culture-bound divergent meanings. Failing to recognize the underlying discrepancies in these elements between cultures will result in misunderstanding.
Dumessa, M. & Godesso, A.	Explorations of Intercultural Communication Barriers among the Students of College of Social Sciences and Law at Jimma University, Oromiya, Ethiopia	2014 (Journal)	Qualitative descriptive Aim: To explore intercultural communication barriers among the students of college of social sciences and law at Jimma University	The research found that the barriers for intercultural communications among the students from various linguistic and cultural backgrounds were ethnocentrism, prejudice, past historical back drops, linguistics and sociocultural variations. Sometimes misunderstanding occurs due to cultural competition and political and social reality existing in at the national level at this time of the study. Lack of opportunities created by university structure was also considered as the proximate barriers for intercultural communication. Thus, the promotion of tolerance

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				for diversity and multicultural competency has been recommended to be implemented to various level of schooling. Among these, the necessity of learning Afaan Oromo as a course starting from primary school was recommended by students. Moreover, continuous awareness creation program aimed at promoting diversity and tolerance has been expected from university.
Kourkouta L., & Papathanasiou, I. V.	Communication in Nursing Practice	2014 (Journal)	Aim: Provide a discourse on the essence of communication in nurse-patient interaction and nursing education	<p>Communication with the patient is not only based on an innate ability that varies from person to person, but also on the necessary training and experience that one acquires during exercise. The results of this will be to demonstrate greater understanding among patients with greater benefit to patients and personal satisfaction to nurses in the performance of nursing. Good communication also improves the quality of care provided to patients, which is observed in the results. Additionally, it is considered an inalienable right and a prerequisite for building a genuine and meaningful relationship between patients and nurses and other health professionals.</p> <p>In nursing profession, there is a need for dialogue and a good interpersonal climate that develops personally with each sick person, especially in our modern multicultural society.</p>
Huang J., Dotterweich, E., & Bowers, A.	Intercultural Miscommunication: Impact on ESOL	2012 (Journal)	Aim: To examine the nature of intercultural communication, the causes of intercultural miscommunication,	Intercultural miscommunication occurs due to these cultural differences. ESOL teachers need to understand that students' cultures affect their learning of

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	Students and Implications for ESOL Teachers		and its impact on ESOL students	a language and cultural and linguistic differences hold the potential for intercultural miscommunication. Therefore, ESOL teachers need to use a variety of strategies to help prevent intercultural miscommunication from occurring within the classroom
Jonasson, C. & Lauring, J.	Cultural differences in use: the power to essentialize communication styles	2012 (Journal)	Qualitative. Aim: To argue that attention should not only be directed at national differences and that more interest should be paid to the actual use of those differences in communication	Illustrations of how individuals and groups may essentialize cultural differences during intercultural business encounters and how this fixation of cultural traits can be used in social stratification are provided.
Crawford, T., Candlin, P., & Roger, S.	New perspectives on understanding cultural diversity in nurse—patient communication	2017 (Journal Article)	Aim: discusses intercultural nurse—patient communication and refers to theoretical frame-works from applied linguistics to explain how miscommunication may occur	It illustrates how such approaches will help to raise awareness of underlying causes and potentially lead to more effective communication skills, therapeutic relationships and therefore patient satisfaction and safety.
Gerlach, H., Abholz, H.-H., Koc, G., Yilmaz, M., & Becker, N.	"As a migrant I wish not to be treated differently" Focus-groups on the experience of patients with migration background from Turkey	2012 (Journal)	Qualitative N=39 Aim: To examine the perceptions of immigrants with respect to their experience with healthcare	Misunderstandings, prejudices and discrimination were often mentioned by the participants as being based on their migration background. Unequal care was experienced by most of them. Participants stressed that empathy was often missing in the doctor-patient-relationship resulting in no trust in the relationship, anxieties, insecurity and doctor hopping. They wished to be seen and treated as individuals with equal rights. Relevant "culture-specific" problems were not mentioned except when being seen as instrumentalized for discrimination. They wished

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				<p>competence in intercultural communication to be integrated in continuous medical education to reduce discrimination.</p> <p>Different from other countries intercultural communication and competence is not part of continuous medical education in Germany. Intercultural communication should focus on the variability of individuals and not on the construction of "rules" for the appropriate behaviour in contact with people from "different cultures".</p>
Hamilton and Wooward-Kron	Developing cultural awareness and intercultural communication through multimedia: A case study from medicine and the health sciences	2010 (Journal)	<p>Aim: To outline how this sensitivity can be enhanced through teaching that develops reflectiveness as practice for analyzing and understanding the interrelationship of language, communication and culture.</p>	<p>Simulated interactions of these ESP learners in clinical settings provide triggers for classroom discussion, build reflective practice skills, and develop the requisite language competence and clinical communication skills. The discussion includes strategies for implementation and evaluation of the multimedia supported methodology.</p>
Henderson, S., Baker, M., & Mak, A.	Strategies used by nurses, academics and students to overcome intercultural communication challenges	2016 (Journal)	<p>Qualitative: focus group and telephone interviews.</p> <p>Purposive sampling.</p> <p>N=19 clinical facilitators, 5 clinical nurses, 10 nursing students, and 7 nurse academics</p> <p>Aim: To explore the experiences of clinical nurses, nurse academics, and student nurses regarding intercultural communication challenges</p>	<p>Four categories emerged: 1) prejudice based on cultural diversity; 2) unfamiliarity with cultural boundaries; 3) stereotyping cultural behaviours; and 4) difficulty understanding English. Strategies participants used to mitigate challenges included resorting to cultural validation through alliance building, proactively seeking clarification, and acquiring cultural awareness knowledge. Also identified that aps exist in the literature regarding intercultural communication resources for students, academics and clinicians.</p>
Jaeger, K.	Adopting a Critical Intercultural	2012 (Journal)	<p>Literature Review</p> <p>Aim: To demonstrate</p>	<p>The mutual interest in intercultural communication in</p>

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	<p>Communication Approach to Understanding Health Professionals' Encounter with Ethnic Minority Patients</p>		<p>how healthcare discourses on ethnic minority patients reflect shifting intercultural communication paradigms and advocate the adoption of a critical intercultural communication approach in relation to ethnicity-based health inequality</p>	<p>healthcare settings has provided a fertile ground for knowledge exchange, for example in the form of continuing education programs for health professionals. The effects of the dominating position of interpretive intercultural communication research has led to an emphasis on the individual patient, an adaptive and reflective approach to culture and a dedicated attempt to avoid collective representations or ethnic labeling when addressing immigrant patients in discourse or practice. The main difference between the interpretive and the critical paradigm is the propensity of the latter to include macro perspectives such as historical, political, and social factors in research on intercultural contact. a critical intercultural communication approach in fact represents a paradigmatic shift is underlined by the fact that constituting concepts of intercultural communication theory: culture, communication and cultural identity are subjected to inquiry and reformulation</p>
<p>Kale, E. & Syed, H. R.</p>	<p>Language barriers and the use of interpreters in the public health services. A questionnaire-based survey</p>	<p>2010 (Journal)</p>	<p>Quantitative Aim: To examine cross-cultural communication in health-care settings, which has implications for equal access to health service</p>	<p>Our results suggested an underutilization of interpreter services in the public health-care system. The use of interpreter services seems to be sporadic and dependent on the individual healthcare practitioner's own initiative and knowledge. Many survey participants expressed dissatisfaction with both their own methods of working with interpreters and with the interpreter's qualifications. A key area for further improvement is the process of raising awareness among healthcare providers and institutions</p>

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				regarding the legal responsibility they have to ensure the sufficient level of communication with their patients/clients
Fall, L. T., Kelly, S., Macdonald, P., Primm, C., & Holmes, W.	Intercultural Communication Apprehension and Emotional Intelligence in Higher Education	2013 (Journal)	Quantitative Aim: To examine emotional intelligence as a predictor of intercultural communication apprehension among university students	Results indicate that three of the emotional intelligence subscales predict intercultural communication apprehension: emotionality, sociability, and self-control. These results support the premise that emotional intelligence manages and/or reduces intercultural communication apprehension and therefore should be integrated in business curriculum.
Oliveira, M.d. F.	Multicultural Environments and Their Challenges to Crisis Communication	2013 (Journal)	Qualitative Aim: To provide the foundation or an in-depth understanding of crises, where scholars and professionals can pair crisis strategies with audiences' cultural expectations	Public relations practitioners had difficulties in defining multiculturalism, often equating cultural diversity with communicating with Latinos. Interviewees saw cultural differences as just one aspect of diversity, emphasizing that age, religion, and education differences also affect corporate discourse. Although professionals considered culture a key element of crisis management, they did not feel prepared to handle the challenges of a multicultural crisis, nor did they report that they used culturally adjusted crisis strategies often. Recommends introducing training initiatives focused on increasing levels of cultural competence to make organizations and communication professionals ready to the challenges of a global market.
Oberg, K.	Cultural shock: Adjustment to new cultural environments	1960 (Journal)		
Hu, Y., & Fan, W.	An exploratory study on intercultural	2010 (Journal)	Literature review N=368 intercultural	The results indicate that intercultural communication

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	communication research contents and methods: A survey based on the international and domestic journal papers published from 2001 to 2005.		communication articles Aim: To discern the current trends of intercultural communication research in China and abroad and furthermore provide suggestions for future research	research in China is sharply different from research abroad with regards to research contents and methods. The main concern of researchers abroad is intercultural adaptation and intercultural training while the Chinese researchers are mainly concerned with cross-cultural pragmatics. As far as research methods are concerned, most studies abroad are conducted using empirical research methods, the majority of which adopt the quantitative research method. On the contrary, most studies in China are non-empirical research. Of the small number of empirical studies, considerable attention is paid to the mixed use of both qualitative and quantitative research methods. At the end of the paper, constructive suggestions are made for future research
Cargile, A. & Bolkan, S.	Mitigating inter- and intra-group ethnocentrism: Comparing the effects of culture knowledge, exposure, and uncertainty intolerance	2012 (Journal)	Literature review Aim: To observe how, among a sample of intercultural communication student respondents, cultural knowledge, cultural exposure, uncertainty intolerance, stress, intergroup ethnocentrism, and intragroup ethnocentrism all interrelate	Findings suggest that a staple pedagogical approach is perhaps less effective than a potential new one: reduced levels of both forms of ethnocentrism were engendered by uncertainty tolerance but not cultural knowledge.
Grant, J., & Luxford, Y.	Culture is a big term isn't it?' An analysis of child and family health nurses' understanding of culture and intercultural understanding	2011 (Journal)	Qualitative: Ethnography Aim: To explore how child and family health nurses appear to understand and use constructs of culture and multicultural during everyday, intercultural	By analysing these understandings through postcolonial and feminist theories we found pervading evidence that neo-colonial constructs of a white western monoculture shaped intercultural communication practice. We conclude by reflecting on how these constructs might be

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			communication with parents who are new to Australia and Australian health services	addressed to improve intercultural communication in child and family health settings
McKeary, M. & Newold, B.	Barriers to Care: The Challenges for Canadian Refugees and their Health Care Providers	2010 (Journal)	Qualitative Aim: To explore the systemic barriers to health care access experienced by Canada's refugee populations	Based on the interviews, barriers include issues of interpretation/language, cultural competency, health care coverage, availability of services, isolation, poverty, and transportation, issues that were observed regardless of refugee classification. Results also revealed the difficulties of language, both from a provider as well as client perspective, with language barriers impacting service provision on the part of health care professionals, client understanding, prescriptions and telephone communications. Strategies to promote cultural competencies include sensitivity training and evaluation, hiring professionals who share clients' ethnicity or language, and developing interpretation services
Liddicoat, A. J.	Communication as Culturally Contexted Practice: A View from Intercultural Communication	2012 (Journal)	Literature review Aim: To explore the interrelationship between culture, language and communication and examine dimensions of the impact of culture on the act and process of communication.	Culture impacts on communication at a number of levels. What is communicated depends as much on the cultural context in which the communication occurs as it does on the elements from which the linguistic act is constructed. Culture also influences how the linguistic act itself is constructed, affecting text types and the properties and purposes of textual structures. It influences perceptions of the communicative purpose associated with particular types of linguistic acts at particular moments of interaction and also of the interactional and

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				<p>interpersonal value of linguistic acts. Finally, culture is a feature of the form of the language which is used to construct linguistic acts.</p> <p>The culturally contexted nature of communication therefore imposes a problem of inter-translatability for actual instances of communication across languages and cultures and necessitates a level of particularity for each actual instance of communication</p>
Stadler, S.	Cultural differences in the orientation to disagreement and conflict	2013 (Journal)	Aim: To discuss differences in orientation towards disagreement and the resolution of conflict and the implications that failure to adhere to cultural expectations can evoke.	
The American College of Obstetricians and Gynecologists	Cultural Sensitivity and Awareness in the Delivery of Health Care	2011 (Journal)	Literature Review Aim: To discuss how understanding the cultural context of a particular patient's health-related behavior can improve patient communication and care	<p>Not all cultural competency issues relate to foreign languages or cultures. Cultural competency encompasses gender, sexual orientation, socioeconomic status, faith, profession, tastes, disability, age, as well as race and ethnicity.</p> <p>Physicians should be sensitive to the unique needs of women in the communities they serve. Sensitivity to patients' reactions and possible behavioral differences will alert clinicians to ask appropriate questions and take appropriate actions. Using open-ended questions and active listening with patients is important.</p>
Garrido M. M., Dlugasch, L., & Graber, P. M.	Integration of interprofessional education and culture	2014 (Journal)	Quantitative Aim: To describe the development and integration of a	The Cultural Awareness Scale revealed that FNPs became more comfortable interacting with diverse patients. Critical reflection essays and clinical

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	into advanced practice simulations.		simulation initiative that simultaneously incorporated interprofessional and cultural competencies in a graduate family nurse practitioner (FNP) and health care sciences curriculum	case analysis supported that FNPs are becoming culturally competent. On the Attitudes Toward Health Care Teams Scale athletic training, and physical therapy students felt team collaborations were poor but shared leadership was valued; the FNP data was just the opposite. This initiative was successful in simultaneously incorporating interprofessional education and culture in simulation; however, the students' varying experiences influenced outcomes.
Nagle, G., McHale, J., Alexander, G., & French, B.	Incorporating Scenario-Based Simulation into a Hospital Nursing Education Program	2009 (Journal)	Literature review Aim: To provide an overview of the historical basis for using simulation in education, simulation methodologies, and perceived advantages and disadvantages.	It provided a description of the integration of scenario-based programs using a full-scale patient simulator into nursing education programming at a large academic medical center.
Wiggins, B. E.	Towards a model of intercultural communication in simulation	2012 (Journal)	Literature Review Aim: To discuss a number of valuable aspects of training simulations designed to improve intercultural literacy	Practical application of national cultures in a simulation appears to have both merits and drawbacks. Perhaps a merging of synthetic and national cultures in a simulation would be effective given an inductive approach at educating participants about nuances of intercultural communication. Nevertheless, from the little content present in the screenshots, it appears that participants of the ARGONAUTONLINE simulation would likely be expected to make decisions based on less than desirable information. Unfortunately, no thorough evaluation of several intercultural e-learning simulations and games has been done. The point of the Model

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				<p>for Intercultural Communication in</p> <p>Simulations is first to promote discussion and debate, but should also act as a design model for simulations whose participants should gain a deeper intercultural literacy. The model is rich in theory; the next step is development and testing</p>
Burke, S. C., Chaney, B. H., & Kirsten, W.	International Videoconferencing for Public Health Education: Linking the U.S. and Germany	2010 (Journal)	Quantitative Aim: To present a case study of international videoconferencing in the higher education setting	Utilizing this technology for fostering intercultural communication proved to be an effective method of instruction for student participants. Intercultural communication has become a marketable skill for future public health professionals, and incorporating these communications skills into professional preparation programs provides unique learning experiences for students. Videoconferencing technology provides learners with synchronous experience for interacting with other cultures furthers understanding about global perspectives. Today, globalization introduces challenges and opportunities for health educators. Moreover, increasing communication and fostering dialogue between the future public health leaders improves knowledge levels and ideas for resource utilization.
Wros, P., & Archer, S.	Comparing learning outcomes of international and local community partnerships for undergraduate nursing students	2010 (Journal)	Aim: Not explicitly stated	During a month-long travel course to Cameroon, West Africa, students improved their skills in clinical assessment, data management, intercultural communication, and collaboration based on an empowerment model of international partnership.
Parent, R.	Intercultural exchange: An approach to	2007 (Journal)	Aim: The current challenges of	The anthropological definition of culture as a 'semiotic', or

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	training from a Franco-Canadian perspective		cultural diversity necessitate effective methods for training professionals in health, as well as other sectors, to work with the phenomenon of culture. This paper presents an overview of a semiotic-based approach to training in this regard	universe of meaning, offers interdisciplinary common ground for designing practical approaches to cultural analysis, intercultural communication and creativity training. This definition is consistent with convergent findings and research practice in social and cognitive psychology, administrative science, philosophy, ethnography, linguistics and semiotics. Cultural performances such as narrative constitute an effective methodological tool for interdisciplinary data gathering and for analysis of all kinds of cultures: organizational, family, ethnic, regional, trans border, etc. When combined with a functionalist and systemic approach to the study of culture, semiotic approaches to narrative analysis provide useful principles for decoding cultural modes of communication and for designing meaningful change based on cultural specificity.
Aboriginal Nurses Association of Canada, Canadian Associations of Schools of Nursing, Canadian Nurses Association	Cultural Competence and Cultural Safety in Nursing Education - A Framework of First Nations, Inuit and Metis Nursing	2009 (Journal)	Aim: To address concerns of cultural diversity and create awareness of First Nation, Inuit and Métis peoples in nursing education programs across Canada.	Eight concepts were articulated from synthesis of literature and a conceptual framework was developed and presented to the Board of Directors of the CASN for their review and feedback. This guided the development of this document, Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing. Of the eight concepts developed, six are presented as core competencies and two serve as foundational structures or processes supportive of Aboriginal nursing education

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Ying, H. & Ying, K.	Empirical Study on Intercultural Communication Teaching for English Majors in Chinese Universities	2012 (Journal)	Aim: To explore students' perception of present intercultural communication course in terms of purpose of learning, content and effective approaches, expectations for teachers and suggestions for improving the course.	Some implications on intercultural communication teaching are discussed. Teachers should help students to develop appropriate cultural attitudes and improve their intercultural communication competence so as to meet the demand of the globalized world. Meanwhile, collaboration among researches and teachers are advocated to improve teaching of intercultural communication.
Beischel, K. P.	Variables Affecting Learning in a Simulation Experience: A Mixed Methods Study	2013 (Journal)	Mixed methods N=124 Aim: To test a hypothesized model describing the direct effects of learning variables on anxiety and cognitive learning outcomes in a high-fidelity simulation (HFS) experience. The secondary purpose was to explain and explore student perceptions concerning the qualities and context of HFS affecting anxiety and learning	Being ready to learn, having a strong auditory-verbal learning style, and being prepared for simulation directly affected anxiety, whereas learning outcomes were directly affected by having strong auditory-verbal and hands-on learning styles. Anxiety did not quantitatively mediate cognitive learning outcomes as theorized, although students qualitatively reported debilitating levels of anxiety. This study advances nursing education science by providing evidence concerning variables affecting learning outcomes in HFS.
Hallin, K., Häggström, M., Bäckström, B., & Kristiansen, L. P.	Correlations between Clinical Judgement and Learning Style Preferences of Nursing Students in the Simulation Room	2016 (Journal)	Quantitative Aim: To explore three specific hypotheses to test correlations between nursing students' team achievements in clinical judgement and emotional, sociological and physiological learning style preferences.	Three significant correlations were found between the team achievements and the students' learning style preferences: significant negative correlation with 'Structure' and 'Kinesthetic' at the individual level, and positive correlation with the 'Tactile' variable. No significant correlations with students' 'Motivation', 'Persistence', 'Wish to learn alone' and 'Wish for an authoritative person present' were seen.

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<p>Fleming, S., Mckee, G. & Huntley-Moore, S.</p>	<p>Undergraduate nursing students' learning styles: A longitudinal study</p>	<p>2011 (Journal)</p>	<p>Quantitative N=58 Aim: s to examine changes in students' learning styles over time from a preference and dominance point of view. In addition, the study aimed to ascertain if there was a relationship between students' learning styles on entry to and exit from a four year Bachelor of Science (Nursing) Programme and their age or academic achievement.</p>	<p>The most common dominant learning style in first year was the dual learning category while a large proportion of the students in their final year had no dominant learning style. The preferred learning style of students in their first and final year was reflector. Learning styles were significantly different at the two time points and there was a significant relationship between some learning styles and students' age but not with academic achievement. Total scores of all learning styles showed significant improvements across the two time points of the study. An important implication for nurse education practice is the need for nurse educators to be aware of students' learning styles and in an attempt to maximise students' learning potential, utilise a range of teaching and learning methodologies and assessments that develop all learning styles.</p>
<p>Tanner, K. D.</p>	<p>Talking to Learn: Why Biology Students Should Be Talking in Classrooms and How to Make It Happen</p>	<p>2009 (Journal)</p>	<p>Literature review Aim: To present research evidence that suggests that Student Talk is important in learning, address common challenges that instructors face in getting students talking, and describe some simple teaching strategies that anyone can use tomorrow in their classroom to make Student Talk happen.</p>	<p>Student Talk is key to student learning. In addition, the teaching strategies needed to promote student talk are highly accessible to all biology instructors and are applicable to classroom settings of any size. Whether your teaching philosophy is more aligned with a traditional lecture approach or a more active-learning approach, Student Talk is easily integrated into the classroom in as little as 5 min.</p>
<p>Torre, D.M, Daley, B. J, Sebastian, J. L, & Elnicki, D. M.</p>	<p>Overview of Current Learning Theories for Medical Educators</p>	<p>2006 (Journal)</p>	<p>Literature review Aim: To describe several key learning theories and provides concrete examples of</p>	<p>The 5 learning theories discussed included behaviorist, cognitivist, humanist, social learning, and constructivist orientations to learning. The strength of</p>

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			how specific educational methodologies are linked to these learning approaches	understanding learning theory from multiple perspectives is that it provides medical educators with different teaching strategies that can be retrieved from their educational “tool boxes,” depending on the specific learning outcomes that are desired.
Campinha-Bacote, J.	The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care	2002 (Journal)	Aim: Presents Campinha-Bacote’s model of cultural competence in health care delivery: The Process of Cultural Competence in the Delivery of Healthcare Services	This model views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community). This ongoing process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.
Forbes, M. O., & Hickey, M. T.	Curriculum Reform in Baccalaureate Nursing Education: Review of the Literature	2009 (Journal)	Literature review Aim: To synthesize the recent literature related to curriculum reform and innovation in nursing education	Four themes were identified in the literature: incorporating safety and quality in nursing education, re-designing conceptual frameworks, strategies to address content laden curricula, and teaching using alternative pedagogies. Synthesis of the recent literature in the field will assist faculty who are beginning the curriculum evaluation and revision process in their own schools.
Gaba, D. M.	The Future Vision of Simulation in Healthcare	2007 (Journal)	Literature review Aim: to provide a comprehensive framework for understanding the diversity of applications of simulation in healthcare, as categorized by 11 different dimensions; to provide a vision of how fully integrating	Simulation is a technique—not a technology—to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner. The diverse applications of simulation in healthcare can be categorized by 11 dimensions: aims and purposes of the simulation activity; unit of participation; experience level of participants;

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			<p>simulation into the structures and processes of healthcare can be used to revolutionize patient care and patient safety; and to provide an overview of the driving forces and implementation mechanisms by which different entities may, or may not, promulgate simulation over the next 20 years.</p>	<p>healthcare domain; professional discipline of participants; type of knowledge, skill, attitudes, or behaviors addressed; the simulated patient's age; technology applicable or required; site of simulation; extent of direct participation; and method of feedback used. Using simulation to improve safety will require full integration of its applications into the routine structures and practices of healthcare. The costs and benefits of simulation are difficult to determine, especially for the most challenging applications, where long-term use may be required.</p>
<p>Garrett, B. M., MacPhee, M., & Jackson, C.</p>	<p>Implementing high-fidelity simulation in Canada: Reflections on 3 years of practice</p>	<p>2011 (Journal)</p>	<p>Literature review</p> <p>Aim: To explore our experiences in implementing and using high-fidelity simulation (HFS) over the last three years, in the context of the results of the Canadian Association of Schools of Nursing (CASN) health 2006 simulation survey, which explored the use of simulation across Canada in professional health education.</p>	<p>The rapid increase in the uptake of simulation-based education in Canada is due in large part to the belief that these techniques offer a safe environment for learners to improve competence. Students and teachers have identified positive learning experiences with high-fidelity simulation, particularly with respect to complex patient care scenarios, multidisciplinary team scenarios, student team work (i.e., team-based learning), and reflective debriefing. Despite these benefits there have been significant resource implications from adopting these technologies. The use of team-based learning and reflective debriefing appeared to be a focal area for emphasis in the planning of clinical simulation experiences. A team focused learning approach may also offer a more cost-efficient strategy for clinical simulation.</p>

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Table 2. Other Books Reviewed

Author	Title	Year
Matsumoto, D.	APA Handbook of Intercultural Communication	2010 (Book)
Russel A.	Bridging the cross-cultural gap: Listening and speaking tasks for developing fluency in English.	2009 (Book)
Maclean, S.	Intercultural Communication, v. 1.0	2015 (Book)
Halualani & Nakayama	Critical intercultural communication studies: At a crossroads	2010 (Book)
Majda, A., Zalewska-Puchała, J., Bodys-Cupak, I., & Kamińska, A.	Intercultural education of nurses	2015 (Book)
Hall, T.	Beyond culture	1976 (Book)
Ruppel and Brahm	Intercultural Communication, Overview	2014 (Encyclopedia)

Appendix B: Conceptual Framework

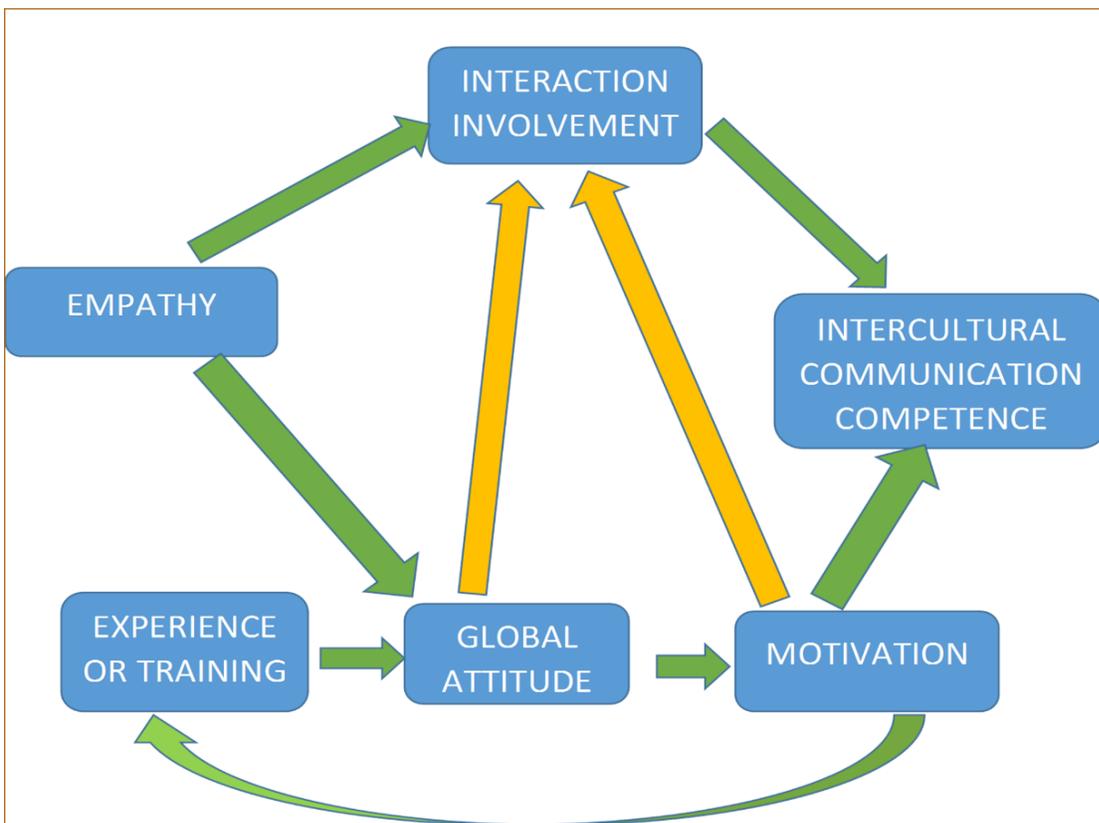


Figure 10. The Integrated Model of Intercultural Communication Competence (IMICC)

Framework. Adopted from Arasaratnam, L. A., & Doerfel, M. L. (2005)



Appendix C: A Letter of Invitation (via blind carbon copy email)

This email is being sent on behalf of Naomi Armah- MN student **Title of Study:**

Undergraduate Nursing Students' Perspectives of Intercultural Communication: A Qualitative Descriptive Study

The purpose of this study is to explore the perspectives of undergraduate nursing students on intercultural communication (ICC) in their nursing education program. Knowing the views of nursing students on the subject matter, their experiences, and suggestion will enable faculty to develop other ways to teach ICC.

Eligibility to participate in this study includes your ability to: i) self-identify as a 3rd or 4th year undergraduate nursing student in College of Nursing, University of Manitoba. ii) have undertaken a cultural diversity/ communication course and engaged in clinical rotation iii) be willing to participate in 45- 60 minutes, audio-recorded, one- on- one interview.

This study is voluntary, and you may choose to withdraw at any time prior to August 31, 2018 at which time data analysis will be completed. Your role in this study will involve sharing your perspectives on ICC; what you recall about ICC content and teaching strategies, personal encounters with culturally diverse clients, and recommendations for future educational strategies. The one-on-one interview is estimated to last between 45- 60 minutes and will be digitally recorded for accuracy purposes. Following the interview, each participant will receive a \$25 gift card each for the University of Manitoba Bookstore. A summary of findings will be emailed to you within 5 months after the interview, so you can verify, refute, or substantiate the

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study's findings. Upon completion of the study, I will provide you with an executive summary of the study's findings via email.

This research has been approved by the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba and the College of Nursing Leadership Team. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 204-474-7122 or by email:

humanethics@umanitoba.ca.

Attached is the consent form for your review. Interested participants are invited to contact me.

Kind Regards,

Naomi Armah

armahn@myumanitoba.ca

Appendix D



LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Undergraduate Nursing Students' Perspectives of Intercultural Communication:
A Qualitative Descriptive Study

Co-Principal Investigators: Naomi Armah, BScN, MN Student

Tel: xxx-xxx-xxxx

Email: armahn@myumanitoba.ca

Donna Martin, RN, PhD, Associate Dean, Research and Associate Professor

89 Curry Place

University of Manitoba

Winnipeg, Manitoba

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Tel: 204- 474- 6716

Email: donna.martin@umanitoba.ca

Co- Investigators: Nicole Harder, RN, PhD, Assistant Professor

Tel: 204-474-6714

Email: nicole.harder@umanitoba.ca

Frank Deer, PhD, Assistant Professor

Tel: 204- 474-9072

Email: frank.deer@umanitoba.ca

This consent form, a copy of which will be provided to you via email and left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The Study

This is a master's thesis. It is aimed at exploring the perspectives of undergraduate nursing students on intercultural communication (ICC) in their nursing education program. The knowledge of ICC may be illustrated by nursing faculty in their teaching strategies and content.

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However, knowing the views of nursing students on the subject matter, their experiences, and suggestion will enable faculty to use more engaging student- centered approaches to teaching to facilitate better outcomes. These issues, along with a paucity of published research relating to the evaluation of and the impact of ICC in nursing education programs provided the researcher with the impetus to undertake this qualitative descriptive study.

Eligibility Criteria

Eligibility to participate in this study includes your ability to: i) self-identify as a 3rd or 4th year undergraduate nursing student in College of Nursing. ii) have completed a cultural diversity/ communication course and engaged in clinical rotation. iii) be willing to participate in a 45-60 minutes, audio-recorded, one- on- one interview.

The Study Procedure

This study is voluntary and you may choose to withdraw at any time prior to August 31, 2018 at which time data analysis will be completed. Your role in this study will be to re respond to semi-structured interview questions involve sharing your perspectives on ICC; what you recall about ICC content and teaching strategies, personal encounters with culturally diverse clients, and recommendations for future educational strategies. The one-on-one interview is estimated to last between 45- 60 minutes and will be digitally recorded for accuracy purposes. Following the interview, each participant will receive a \$25 gift card each for academic institution's Bookstore.

A summary of findings will be emailed to you within 5 months after the interview so you can verify, refute, or substantiate the study's findings. Upon completion of the study, I will provide you with an executive summary of the study's findings via email.

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Possible Risks and Discomfort

There are no known risks or discomfort to this qualitative descriptive study, beyond the risks inherent in daily living.

Benefits

By participating in this study, you may reflect on ICC training in your nursing program, provide a deeper understanding of what ICC is in nursing education, help identify the barriers and facilitators of ICC in undergraduate nursing training programs, as well as provide understanding of the perspectives of nursing students on their ICC experiences and the benefit of ICC training in their professional life. It will also assist faculty in identifying the ICC training needs of student nurses as well as the gaps in curriculum and the expectations of students and clinical practice.

Cost for participation

There will not be additional cost for participating. Rather, each participant will be eligible to receive a \$25 incentive for participating in the study.

Confidentiality

All efforts will be put in place to ensure your confidentiality as a research participant is maintained. All identifiable cues will be removed from the data and the researcher will assign pseudo names to the transcripts. Only the researcher will know who has participated in the study. However, this information will not be shared and will be stored on a password protected computer in the Helen Glass Centre for Nursing. The electronic, de-identified data will be stored in a central encrypted server (S: drive) for seven years. The database will have firewalls

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to secure all information, and allow access by authorized, password-protected user accounts only, i.e., the researcher and advisor. This will ensure all study participant information remains confidential and safe. Any hardcopies of the consent forms will be kept in a locked filing cabinet in the advisors' office for seven years, and subsequently disposed of as confidential waste by September 2024. It should be noted that efforts would be made to keep your personal information confidential, however, absolute confidentiality cannot be guaranteed.

The University of Manitoba Education/Nursing Ethics Board may review research-related records for quality assurance purposes and to ensure that the research is being done in a safe and proper way.

Debriefing and Dissemination

The findings from this research will be shared with you and the general populace. You will receive a summary of the final report by email by September 2018. The results will be presented at nursing, education, or communication conferences and published in a journal so that knowledge transfer will be effective.

Questions

If you have any questions regarding this study your rights as a research participant, please contact the following: Naomi Armah (xxx-xxx-xxxx) or Dr. Donna Martin (donna.martin@umanitoba.ca).

Voluntary Participation/Withdrawal from the Study

Your signature to participate in the study indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a

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subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence by informing the researcher. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This research has been approved by the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 204-474-7122 or by email: humanethics@umanitoba.ca. A copy of this consent form has been given to you via email to keep for your records and reference.

Participant signature _____ Date _____

Research and/or Delegate's signature _____ Date _____

Email address to receive research results: _____

Participant's code number: _____

Appendix E: Data Collection Instruments

Before we proceed to talk about ICC, I would like to gather some demographic information about yourself.

Demographic Survey

Title of Study: Undergraduate Nursing Students' Perspectives of Intercultural Communication: A Qualitative Descriptive Study

Do not write your name on this paper. **Note:** You can choose not to answer any question(s).

Please **circle** your answer.

1. What is your gender?

Male Female Other

2. What is your age?

Under 20 years

20 – 24 years

25 – 29 years

30 – 34 years

35 – 39 years

40 – 44 years

45 – 49 years

Over 49 years

3. Do you have a previous undergraduate degree?

Yes No

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4. Is English your primary language?

Yes No

5. How many languages do you speak?

1

2

3

More than 3

6. How would you rate your level of experience with people from diverse cultures?

Limited

Average

Above average

7. Rate your knowledge of intercultural communication.

Limited

Average

Above average

8. Rate your ability to facilitate intercultural communication.

Limited

Average

Above average

Participant's code number: _____

The research has been approved by the Education and Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the University of Manitoba's Human Ethics Coordinator (HEC) at 474-7122 or at humanethics@umanitoba.ca

Semi- Structured Interview Guide

Introduction to the Interview: Thank you for accepting to be a part of this study. The study aims at knowing your views about intercultural communication (ICC) in your nursing education program.

Note: Probes and prompts will be used as and when necessary to elicit further discussion. Some of the probing questions are bulleted under the main questions below.

1. In your theory and clinical courses you may have been introduced to ‘ICC’. When you hear this term, what comes to mind?
 - What does ICC mean to you as an individual?
 - Would you say one’s cultural background has an influence with ICC encounters with people from diverse cultural backgrounds? Why or why not?
 - How did you learn about ICC in your nursing program? What teaching strategies were used – lectures, simulation, role plays, case studies, actual patients?
 - What learning opportunities were most helpful?
 - What learning opportunities were least helpful?
2. Think about the last time you participated in ICC. Tell me what happened.
 - Can you expand on that?
3. As a student nurse, what factors prevent you from facilitating ICC?
4. As a student nurse, what factors help you to facilitate ICC?
 - What things prepared you to care for culturally diverse clients?

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5. Can you describe a situation when ICC went well or did not go well?
 - Why did it go well/ why did it not go well?
 - How has the information you received on ICC affected your attitude towards care for culturally diverse clients?
 - Reflecting on your first year in nursing until now, how has the information you received on ICC affected your interaction or involvement with culturally diverse clients?
 - How has the information you received on ICC motivated you to communicate with culturally diverse clients?

6. What could help you develop further ICC skills?
 - Do you believe the information you received on ICC adequately prepared you to communicate with culturally diverse clients during your clinical courses? Tell me more about that.
 - What do you think is the best teaching/learning approach to prepare nursing students for ICC?
 - What else do you believe can be incorporated into classes, simulation, clinical courses to facilitate more effective ICC?
 - What additional resources do you believe would be needed to enhance ICC?

7. What is the most important point about ICC that you would want to share?
 - From your experience so far, what would you say are the benefits of engaging in ICC education?

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8. Is there anything else you would like to share with me?

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Guide for Reflective Memo

1. Describe the interview location and the interview process.
2. Document key statements that depicted how the participant perceived and experienced ICC.
3. Identify what worked well in the interview process and what could be enhanced in future interviews.
4. What aspects of the participant's perceptions and experiences were similar or different to mine?
5. Was the data congruent or different from the components of the guiding framework? Explain.