NURSES' PERSPECTIVES ON CARING FOR CLIENTS IN A CULTURALLY DIVERSE PAEDIATRIC SETTING

by

Mary Gervaise Elizabeth Spencer

B.N. University of New Brunswick, 1982

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE DEGREE OF MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

(School of Nursing)

We accept this thesis as conforming to the required standard

The University of British Columbia
August 1994

© Mary Gervaise Elizabeth Spencer, 1994
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of Applied Science, School of Nursing

The University of British Columbia
Vancouver, Canada

Date Aug. 29/94
ABSTRACT

The increasing cultural diversity of British Columbia is affecting the delivery of health care. Although there is extensive literature outlining the knowledge and skills required by nurses to provide culturally sensitive care, little is known about the perspective of nurses providing this care. The purpose of this study was to identify and describe the main issues for nurses who cared for culturally diverse clients and families in a paediatric inpatient setting. The second focus of this study was to describe the resources and supports nurses utilized and needed in order to provide this care. Kleinman's (1978) conceptualization of the three domains in which health is experienced and reacted to provided direction for examining the effects of conflicting explanatory models of health and illness from the nurse's perspective. A descriptive approach was used to address the following two research questions: 1) What issues do nurses identify as influencing their ability to provide culturally sensitive care in a paediatric setting? and 2) What agency-based resources facilitate or hinder the nurses' ability to provide culturally sensitive care?

The investigator used a convenience sampling approach to recruit 42 respondents from a paediatric inpatient setting. A questionnaire developed and piloted
by Lynam, Sauro et.al (1990) was adapted and used for this study. Content analysis was used to analyze open-ended responses, and descriptive statistics were calculated for the fixed-response questions.

Communication was the overriding issue paediatric nurses faced. The communication barrier influenced the nurses' ability to assess clients and to provide care. When nurses were unable to provide optimal care, they experienced frustration and moral and ethical dilemmas.

Nurses reported their ability to provide care was dependent upon the resources available. Difficulties were overcome when the nurse's personal philosophy valued client differences, and enabled her to negotiate with the client. Availability of interpreter services and resources to assist communication also affected the nurse's ability to provide care.

Implications arising from this study for nursing education, practice and research are discussed.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>iv</td>
<td>Table of Contents</td>
<td>iv</td>
</tr>
<tr>
<td>vi</td>
<td>List of Figures</td>
<td>vi</td>
</tr>
<tr>
<td>vii</td>
<td>Acknowledgements</td>
<td>vii</td>
</tr>
<tr>
<td>1</td>
<td>CHAPTER ONE: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Background to the Problem</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Problem Statement and Purpose</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>Conceptualization</td>
<td>8</td>
</tr>
<tr>
<td>11</td>
<td>Significance of the Study</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>Research Questions</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Definition of Terms</td>
<td>13</td>
</tr>
<tr>
<td>13</td>
<td>Assumptions</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>Limitations</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>CHAPTER TWO: REVIEW OF THE LITERATURE</td>
<td>15</td>
</tr>
<tr>
<td>15</td>
<td>Theoretical Perspectives</td>
<td>15</td>
</tr>
<tr>
<td>18</td>
<td>The Nurses' Perspective</td>
<td>18</td>
</tr>
<tr>
<td>24</td>
<td>Knowledge and Skills Required for Culturally Sensitive Care</td>
<td>24</td>
</tr>
<tr>
<td>28</td>
<td>Institutional Supports to Overcome Barriers</td>
<td>28</td>
</tr>
<tr>
<td>34</td>
<td>Literature Summary</td>
<td>34</td>
</tr>
<tr>
<td>37</td>
<td>CHAPTER THREE: METHODOLOGY</td>
<td>37</td>
</tr>
<tr>
<td>37</td>
<td>Design</td>
<td>37</td>
</tr>
<tr>
<td>37</td>
<td>Instrument</td>
<td>37</td>
</tr>
<tr>
<td>41</td>
<td>Selection Criteria</td>
<td>41</td>
</tr>
<tr>
<td>41</td>
<td>Protection of Human Rights</td>
<td>41</td>
</tr>
<tr>
<td>42</td>
<td>Sample Selection</td>
<td>42</td>
</tr>
<tr>
<td>42</td>
<td>Sample Recruitment</td>
<td>42</td>
</tr>
<tr>
<td>43</td>
<td>Data Collection</td>
<td>43</td>
</tr>
<tr>
<td>43</td>
<td>Response Rate</td>
<td>43</td>
</tr>
<tr>
<td>44</td>
<td>Data Analysis</td>
<td>44</td>
</tr>
<tr>
<td>46</td>
<td>Summary</td>
<td>46</td>
</tr>
<tr>
<td>48</td>
<td>CHAPTER FOUR: PRESENTATION AND DISCUSSION OF FINDINGS</td>
<td>48</td>
</tr>
<tr>
<td>48</td>
<td>Description of the Setting</td>
<td>48</td>
</tr>
<tr>
<td>51</td>
<td>Findings Related to the First Research Question</td>
<td>51</td>
</tr>
<tr>
<td>51</td>
<td>Issues Related to Communication</td>
<td>51</td>
</tr>
<tr>
<td>52</td>
<td>Assessment of the Client</td>
<td>52</td>
</tr>
<tr>
<td>53</td>
<td>Urgency of the Situation</td>
<td>53</td>
</tr>
<tr>
<td>53</td>
<td>Nature of the Information</td>
<td>53</td>
</tr>
<tr>
<td>54</td>
<td>Complete client history</td>
<td>54</td>
</tr>
<tr>
<td>54</td>
<td>Client and family's response</td>
<td>54</td>
</tr>
<tr>
<td>56</td>
<td>Appraisal of cultural meaning</td>
<td>56</td>
</tr>
<tr>
<td>61</td>
<td>Process of Providing Care</td>
<td>61</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Supporting and Reassuring</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Conveying Crucial Information</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Consequences for Nurses</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>Frustration</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Moral and Ethical Dilemmas</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Influences on Practice</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Personal Philosophy</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Interpretation</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Findings Related to the Second Research Question</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Resources used to Address Communication Difficulties</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Interpreter Use</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Perceived Availability</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>Perceived Cost</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Use of Other Resources</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Urgency</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>Limited Access</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>Appropriateness of Resources</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>Resources Used to Enhance Cultural Awareness</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>Sources of Knowledge</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Availability of Resources</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Additional Findings</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>Processes of Providing Care</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Consequences for Nurses</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Frustration</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Moral and Ethical Dilemmas</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>Influencing Factors</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>Personal Philosophy</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>Communication Resources</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>Staff Development</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>Broader Issues in Health Care Delivery</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>CHAPTER FIVE: Summary, Conclusions and Implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>116</td>
<td></td>
</tr>
<tr>
<td>Conclusions</td>
<td>119</td>
<td></td>
</tr>
<tr>
<td>Implications</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Nursing Practice</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Nursing Education</td>
<td>123</td>
<td></td>
</tr>
<tr>
<td>Nursing Research</td>
<td>124</td>
<td></td>
</tr>
<tr>
<td>REFERENCES</td>
<td>127</td>
<td></td>
</tr>
<tr>
<td>APPENDICES</td>
<td>133</td>
<td></td>
</tr>
<tr>
<td>Appendix A: Instrument</td>
<td>134</td>
<td></td>
</tr>
<tr>
<td>Appendix B: Letter to head nurse</td>
<td>144</td>
<td></td>
</tr>
<tr>
<td>Appendix C: Letter to participants</td>
<td>145</td>
<td></td>
</tr>
<tr>
<td>Appendix D: Participant information</td>
<td>146</td>
<td></td>
</tr>
</tbody>
</table>
List of Figures

Figure 1. Kleinman's Cultural Systems Model. 10
Figure 2. Types of Interpreters used in Practice. 81
Figure 3. Responsibility for Organizing Interpreters. 81
Figure 4. Northouse and Northouse (1985) Health Communication Model. 95
ACKNOWLEDGEMENTS

I owe thanks to many people for their assistance in achieving this goal. To my parents for their unfailing support and belief in me. To my Aunt Mary for her inspiration. To my brothers and their families for their continuing love and encouragement.

To my committee members, Professor Judith Lynam, Professor Connie Canam and Dr. Sally Thorne for their challenges and words of encouragement and support. Particular thanks to Professor Lynam for her insight and inspiration when I was struggling.

To the nurses at BCCH who participated in this study and allowed me to understand their perspective. To my colleagues at work whose understanding allowed me the time and flexibility to pursue this goal.

To my eleventh hour editors Katie and Jim.

Last but not least, I am especially grateful to my friends Vicky, Linda, and Betty for helping me gain perspective during this long, challenging and sometimes lonely process.
CHAPTER ONE
INTRODUCTION

Background to the Problem

Trends in immigration indicate that the number of immigrants will increase each year to maintain Canada's population at its current level (Burke, 1992). In 1990, 28,000 immigrants settled in British Columbia, which was double the number in 1985 (Ministry for Multiculturalism and Immigration (MMI), 1991).

The profile of new Canadians is changing from predominantly British and European immigrants prior to 1981, to over 70% South and South East Asians in the past decade (MMI, 1991). Of the immigrants to British Columbia in 1990, approximately half spoke English as their first language (MMI, 1991). Consequently, the population needing health care services in this province includes a growing number of individuals with cultural backgrounds and language abilities very different from the Western anglophone majority who comprise most of the health care professionals. To meet the needs of the changing population, Canada's health care system must respond to the challenge and adopt a multicultural perspective.

Culture plays a vital role in determining how we define and seek to attain health (Leininger, 1978). Each individual has a unique concept of health and illness, formed through personal experiences, social context and
the ethnocultural group with which they identify. The family is perhaps the most important social context in which health is learned and illness is managed. Family roles, childrearing practices and responses to illness differ among cultures (Neiderhauser, 1989).

Culture and ethnicity are often used synonymously. However, culture is not solely determined by ethnicity. Factors such as religion and acculturation come into play, and individuals identify with a variety of cultural groups within their social context (Waxler-Morrison, Anderson, & Richardson, 1990). For the purposes of this paper, the term ethnocultural groups will be used to identify those whose ethnicity and / or culture differ from those of the majority.

A survey conducted by the Social Planning Council of Toronto found that members of ethnocultural minority groups experience difficulty accessing appropriate health care services (Doyle & Visano, 1987). Some of the barriers included limited language ability, cultural practices unfamiliar to health care workers, limited awareness of rights and entitlements, and limited knowledge of available services. The British Columbia Royal Commission on Health Care and Costs (1991) reported similar barriers which influenced the delivery of effective health care to Canadian immigrants.
It can be argued that ineffective health care is expensive in both human and financial terms, contributing to higher mortality and morbidity among ethnocultural minority groups. Ruffin (1979) identified an apathy within the American health care system with regard to its responsibilities towards some ethnic groups. The consequences of this professional attitude are higher mortality rates, and a greater severity of illness (Ruffin, 1979). Although this was an American study, it can be argued that similar problems exist in Canada. For example, clients who do not seek or receive appropriate treatment often go on to develop more serious illnesses and therefore use more health care dollars in the long run.

Health care that is not culturally responsive is likely to be ineffective (Fong, 1985; Louie, 1985; Masi, 1990), and nurses who are not sensitive to cultural issues provide less than optimal care (Branch & Paxton, 1976; McCabe, 1960; Meuke, 1970; Murphy & Clarke, 1993; Rothenburger, 1990).

Several authors have reported that nurses experienced difficulties providing care to clients from ethnocultural groups different from their own (Leininger, 1967; Louie, 1985; McCabe, 1960; Murphy & Clarke, 1993). Common themes identified in these experiences included
problems communicating, with both the client and family, and a lack of knowledge about the client's culture (Leininger, 1967; Louie, 1985; McCabe, 1960; Mueke, 1970; Murphy & Clarke, 1993; Rothenburger, 1990). These problems resulted in stress and frustration for nurses and a perceived lower standard of care for the client (McCabe, 1960; Murphy & Clarke, 1993). Nurses who provide care to clients from various ethnocultural groups need to be cognizant of factors which facilitate or impede therapeutic interaction between the nurse and the client.

In recent years, attempts to redress the identified difficulties have resulted in a wealth of information which explored the cultural aspects of caring (Fong, 1985; Lawson, 1990; Leininger, 1978; Lipson & Meleis, 1985; Louie, 1985; Spector, 1991; Waxler-Morrison et al., 1990), and which advocated the use of various models and conceptual approaches in the process of providing culturally sensitive care (Anderson, 1990; Fong, 1985; Kleinman, Eisenberg & Good, 1978; Tripp-Reimer, Brink & Saunders, 1984). Some agency-based resources such as interpreters, written material for clients, and inservices related to culture and health have been developed to assist nurses in providing culturally appropriate care (Harris & Tuck, 1992; Malone, 1993; Rader, 1988).
Despite the existing information and identified resources, many nurses continued to experience difficulty working with clients from cultures different from their own. In 1978, Leininger (1978) identified a gap between what is known about providing culturally sensitive care, and what is actually practised. Leininger (1978) advocated eliciting from the nurses themselves the issues involved in caring for clients from other cultures. Yet, sixteen years later, the perspective of the nurse in providing culturally sensitive care remains an underdeveloped area of nursing research, particularly in the field of child and family nursing.

A student pilot project supervised by Lynam, and conducted by Lynam, Sauro et al., (1991) sought to describe what nurses saw as the issues they faced when caring for clients from diverse cultures. A researcher-developed questionnaire entitled Nursing in a Multicultural Society: Issues and Nursing Responses (NMS-INR) was used. The pilot study was conducted with twenty-two nurses in adult acute care settings. An analysis of the findings indicated that nurses experienced problems with issues related to communication, clients' adherence to hospital regulations and differing religious beliefs. In settings in which the study was undertaken, inservice education related to cultural aspects of care was
unavailable and nurses gained their knowledge about a client's culture from their own work experience. Interpreters were reported to be valuable, but not sufficiently provided. Nurses relied primarily on the client's family to interpret. Nurses were frequently caught in clashes between the agency policies, and their client's wishes.

While there may be common issues across all practice settings, it can be argued that specialty areas experience specific issues and ways of addressing them. The area of interest for this study was a paediatric inpatient setting.

It was expected that paediatric nurses' experiences would be different from those in an adult setting due to the nature of the client and the family-nurse relationship. The family-centred philosophy of paediatric nursing in both acute and long-term care encouraged involvement with the family. Optimal paediatric nursing care during a child's hospitalization included psychosocial interventions such as patient and family teaching, and parental guidance (Brown & Ritchie, 1989; Knafl, Cavallari & Dixon, 1988). For nurses to provide effective family-focused nursing, they must integrate the family's cultural background into each step of the nursing process (Orque, Bloch & Monrroy, 1983).
Childrearing practices and family roles related to child care differ among cultures, and parent's beliefs about childrearing can often be in direct conflict with those of the nurse (Anderson, 1985). Misunderstandings between the family and nursing staff may occur at any stage of the child's care, affecting decision-making, informed consent, and treatment modalities. These misunderstandings occur between families and nurses of similar cultural and language backgrounds, but may be compounded when differences exist.

The mission statement of the British Columbia Children's Hospital (BCCH) Partners in Care Committee (1993) stated family-centred care includes accepting that beliefs about health, child care, the family and the best interests of the child are not absolute values, but are determined by our culture (BCCH, 1993). A recent ethnocultural survey was conducted by British Columbia Children's Hospital (BCCH, 1990) using patient chart reviews and interviews with parents. This survey indicated that 58% of the population was of non-European origin, and 15% spoke a language other than English at home. Four percent of the patient population in this hospital was born outside Canada, and 38% had at least one foreign born parent. Of those surveyed, 25% of the families indicated identity with a specific ethnic or
religious group (BCCH, 1990). These results indicated that the catchment population of Children's Hospital reflected the changing demographics of British Columbia. There is a need to understand how nurses practice a family-centred and culturally inclusive philosophy within a culturally diverse setting, to identify the issues which arise, and to identify resources and supports nurses draw upon when caring for families with different cultural backgrounds.

**Problem Statement and Purpose**

Providing culturally sensitive care can be a difficult process for nurses and may result in stress and frustration for nurses and families, as well as inadequate care for clients. This study described what nurses reported as issues which influenced their ability to provide culturally appropriate care in a paediatric setting, and described agency-based resources which facilitated or hindered the provision of this care.

**Conceptualization**

Kleinman's (1978) cultural systems model illustrates the interactions between different sectors of society in relation to health care. His model was used as a conceptualization for this study (See Figure 1). Kleinman described three distinct, overlapping social arenas in which sickness is experienced and reacted to:
the popular, professional and folk sectors. The popular sector includes the family and social network, and is based on the personal and social experiences of illness. The professional sector includes nursing, medicine and other professionals who explain, manage and understand illness from a biomedical perspective. The third arena concerns the folk or non-professional healers including spiritual healers and herbalists, and is based on sacred and secular perspectives. Some beliefs and values may be common among these sectors, but each ultimately contains a distinct form of social reality due to differing roles, relationships and expectations. The different forms of social reality are called explanatory models, and it is when these models conflict, health care may be impeded (Kleinman, 1978).
Explanatory Model Framework:
Sociocultural Context of Health

FIGURE 1

Adapted by Anderson (1985) from:
Kleinman's (1978) conceptualization postulates that clients often view health and illness from a lay perspective, which differs from that of the professionals. Client-health care professional interactions are transactions between explanatory models. The potential for discrepancies and conflicts between these viewpoints exists and could lead to nursing care that is not client-centred. This potential for discordant views is magnified when the client and professional come from different ethnocultural backgrounds (Kleinman, 1978). Health care professionals must transcend cultural barriers to arrive at an understanding of the individual's experience. One approach, the client-practitioner negotiation model of care (Anderson, 1987; Kleinman, Eisenberg & Good, 1978; Lynam, 1992), proposes that nurses establish a mutual understanding with clients, and identify a common goal and plan to achieve that goal. In this study, a qualitative approach was used to examine how nurses (the professional sector) address issues they identified which arose when providing care within the context of a paediatric acute care setting.

Significance of the Study

This study will enhance the body of knowledge related to the provision of culturally sensitive care in a paediatric setting. It identified issues for paediatric
nurses who provide care for a culturally diverse clientele. As cultural diversity among clients is increasing, administrators need to have an understanding of the issues for nurses, and the supports nurses need to provide culturally appropriate care. It is anticipated that this study will provide direction for the organization to enable the nurse to provide more effective care. It is hoped this study will stimulate further research in the area of nursing care in multicultural settings.

**Research Questions**

This study was directed by the following research questions:

What issues do nurses identify as influencing their ability to provide culturally sensitive care in a paediatric setting?

What agency-based resources do nurses describe as facilitating or hindering the provision of culturally sensitive care?

A descriptive research approach was used to respond to these research questions.
Definition of Terms

**Culture**: "An integrated system of learned patterns of behaviour, ideas and products characteristic of society. It is a philosophy of life and death. Culture is passed on as beliefs, values and mores by significant others, such as parents, other family members and teachers" (Martin & Belcher, 1986, p.231).

**Culturally sensitive care**: "caring that recognizes the uniqueness of views held by all client groups as well as an approach to caring that seeks to consider the social context of people's lives" (Lynam,1991,p.12). For the purposes of this paper, the terms culturally sensitive, culturally appropriate and culturally responsive care are used synonymously.

**Nurses**: Nurses registered with the Registered Nurse's Association of British Columbia who care for children and their families in a paediatric acute care setting.

Assumptions

It was assumed that a sufficient number of paediatric nurses had cared for a child and family whose culture differed from his or her own, and that the nurses were honest in completing the questionnaire. It was also assumed that the responses to the questionnaire related to the actions of nurses in practice.
Limitations

The results of this study are not generalizable to other paediatric nurses, contexts or settings due to the convenience sampling technique used. Participants recalled incidents from the past, therefore, the quality of the data gathered depended on the participants' memory of the events. It was noted that not all participants fully completed the questionnaire.
CHAPTER TWO
LITERATURE REVIEW

The review of the literature will be discussed under the following organizational headings; theoretical perspectives guiding culturally sensitive nursing practice; the nurses' perspective related to providing culturally sensitive care; knowledge and skills needed to provide culturally sensitive care; and the institutional supports to overcome barriers to culturally sensitive care.

Theoretical Perspectives

There are two major theoretical perspectives which guide the practice of culturally sensitive nursing care. The perspectives are those of Leininger (1978) and Kleinman (1978).

Leininger's work (1967, 1970, 1978, 1988) has contributed significantly to the awareness of the need for culturally relevant nursing care. Leininger advocates transcultural nursing, a blend of anthropology and nursing and proposes a theory of culture care diversity. Leininger's (1978) conceptual framework explains nursing through the concept of caring. Caring is the essence of nursing and is a distinct concept which explains and describes nursing (Leininger, 1988). Caring has patterns, processes and expressions that vary across cultures. The
implications for nursing arise from the cultural differences in meaning, nature and expressions of care (Leininger, 1978). The goal of transcultural nursing is to help nurses understand the values and beliefs of different cultures and respond to them in a sensitive manner. This field of transcultural nursing compares and analyses different cultures with respect to caring behaviours and health-illness practices. Critics believe Leininger's focus neglects variables such as class, gender and individual beliefs and values since diversity also exists within a culture and between generations (Wilkins, 1993).

A second theoretical perspective is that of Kleinman (1978). Kleinman's explanatory model conceptualizes three interacting structural domains of health care, the popular, folk and professional sectors, and is used as a conceptual framework for this study (See Figure 1). Kleinman argues that client-health care practitioner interactions constitute transactions between explanatory models. The explanatory models (EMs) of both the professional and popular sectors are culturally shaped. Kleinman's framework provides direction for researchers to examine the issues which arise when the professional EM collides with the popular EM, and to find ways of facilitating the process.
Anderson's (1985) work builds on that of Kleinman, and examines the socio-cultural context of health and illness. Anderson holds that the perception of health and illness are related to the individual's subjective experience as well as cultural context and social organization. The structural features of the health care system and the interactions with health care professionals help determine the client's health care experiences (Anderson, 1985). It is valuable then, to examine the context of providing care, and to look more closely at the interactions between the client and the health care system.

The client-practitioner negotiation model of care proposes that nurses elicit the client's perspective and negotiate care with the client (Anderson, 1987). Thus the expectations and directions for care are not forced upon the client, but are mutually agreed upon.

Kleinman's (1978) theoretical perspective provides us with a framework, a point from which to examine the factors which influence the interaction between client and nurse. The remainder of this literature review will examine literature which addresses the nurse's perspective, the knowledge and skills nurses require to engage in the process of providing care, and the agency supports to overcome barriers to care.
The Nurses' Perspective

There are challenges inherent in the experience of providing culturally sensitive care which have an impact on the nurse's ability to provide optimal care. The nurse's perspective on this experience has been the focus of a number of theoretical works.

In order to understand the nurse's perspective it is necessary to examine the culture of nursing. Kleinman's (1978) work indicated that the field of biomedicine is a unique culture, with its own system of beliefs. Anderson (1987) also argued that nursing has its own sociocultural system based on shared knowledge, beliefs and theories which may be different from those of the client. In addition to their professional culture, nurses have personal beliefs and values which affect their interactions with clients (Anderson, 1987). This theoretical perspective provided direction for further examination of the interactions between nurse and client from the nurses' perspective.

Leininger (1967) argued that nursing is a cultural system with its own beliefs and values. In examining ways in which health care practitioners interact with clients, Leininger (1978) identified several barriers to culturally sensitive care: cultural imposition, cultural blindness and ethnocentricity. Leininger advocated that
an awareness of these barriers would enhance the delivery of culturally sensitive care as nurses would be able to overcome them by being self-aware.

There are a number of research studies which have focused on the process of providing culturally sensitive care from the nurse's perspective. McCabe's (1960) descriptive study found that nurses were frequently frustrated and experienced feelings of inadequacy in their work with clients from 'ethnic minorities'. The experience of the patient and their adjustment to hospitalization was the main focus of the study. As a participant observer however, McCabe noted and gave voice to her co-workers experiences in providing care to culturally diverse clients. Although the nurses in this study had a strong motivation to give good care, they reported a sense of incomplete performance of their jobs. As a result of this sense of incomplete performance the nurses tended to withdraw from their patients, and experienced frustration and dissatisfaction with their jobs. The nurses in McCabe's study indicated they lacked understanding of the client's needs, and encountered a lack of cooperation from their patients. Resources which the nurses may have used or wanted were not explored, nor were suggestions made for providing support for the nurses.
Thirty-three years later researchers again explored the provision of culturally sensitive care from the nurses' perspective. Murphy and Clark (1993) explored the experience of nurses caring for what they called 'ethnic minorities' in England. Semi-structured interviews were conducted with 18 nurses. Respondents were asked to discuss a particular client for whom they had provided care. Areas such as the nurse-client relationship, problems they may have encountered, and the extent to which their training had prepared them for providing care in a culturally diverse setting were discussed. The results of their exploratory descriptive study indicated that many nurses shared common experiences when caring for these patients. Issues related to communication difficulties with both patient and family, and a lack of knowledge about cultural differences were two of the most prevalent issues identified by the nurses. Difficulties were also associated with the nurses' relationships with extended families, and the perceived disruptions in ward routines. These problems resulted in stress for all 18 nurses and what many perceived to be substandard care, resulting from a lack of time and resources to provide this care. All of the respondents in the study felt their basic education had not adequately prepared them for caring for an ethnically diverse client population. How
nurses addressed these difficulties, and the availability and use of institutional resources, either concrete or philosophical, were not explored in this study.

Murphy and Clarke's (1993) study is valuable in documenting that problems do exist for nurses caring for culturally diverse clients. It has not, however, provided direction for supporting the nurses in practice. Little is known about the setting in which Murphy and Clarke's study occurred except that it had a high number of 'ethnic minority' clients. Whether or not there was institutional support for culturally sensitive care was not addressed.

It can be argued that similar issues exist for nurses working in a paediatric setting, however, differences are anticipated due to the nature of paediatric care. As previously discussed, childrearing practices and family roles related to childcare differ among cultures. There may be specific resources nurses in paediatrics use or need to address different issues encountered in a paediatric setting.

A recent research study by Brown and Ritchie (1989) explored the nurse-parent relationship within a paediatric inpatient setting in an effort to understand the nurse's perspective in providing paediatric care. The researchers interviewed 25 nurses to examine nurses'
perceptions of their relationships with parents of paediatric patients. All of the respondents in the study viewed caring for parents as a vital part of their role as paediatric nurses, and felt that children benefitted from having their parents involved in their care. Caring for parents included: supporting and reassuring parents, providing parents with information, teaching them about their child's care, and collaborating with them in the care of the child. The nurses also expected parents to attend to the child's basic care. Brown and Ritchie (1989) found that nurses frequently had difficulty caring for children whose parents did not understand hospital routines and procedures. In many situations it was noted that parents and nurses had different ideas about what was best for the child. The nurses believed in family-centred care, yet they had difficulty providing that care in many situations. Communication difficulties resulted in feelings of powerlessness, frustration, and withdrawal for both parents and nurses. Nurses who were able to overcome communication barriers felt they were able to provide better care to the families. Particular resources the nurses used to overcome barriers and provide the family-centered care they valued were not addressed by Brown and Ritchie in their study.

Knafl, Cavallari and Dixon (1988) sought to explore
how children, parents and nurses define and manage paediatric hospitalization, and how they interacted. Using a symbolic interactionist framework they interviewed 62 families of hospitalized children, and the nurses with whom they interacted. Their findings also indicated that parents were expected to be involved in basic care of their child. Nurses also identified three primary parts to their role as family caregivers; supporting, information-giving, and teaching. Knafl, Cavallari and Dixon (1988) also found that family-centred care needed to be grounded in an understanding of how family members defined the situation, a process best accomplished through negotiation between the parties. Nurses were also noted to experience difficulties communicating with parents from other cultures. Specific supports which may have assisted the nurses were not identified.

The above two studies are valuable in illustrating the complexity of the role of the paediatric nurse, the involvement of parents in basic caregiving, and the importance of the nurse-parent relationship in this specialized area of nursing. These studies examined the relationships between same-language nurses and parents, but it can be argued that these difficulties may be magnified when there are different ethnocultural and
language barriers. As Lawson (1990) indicated, parents' identification with a cultural group may become more intense during times of crisis as they turn to familiar traditions for support.

**Knowledge and Skills Required for Culturally Sensitive Care**

Leininger (1967) advocated the need for nursing curricula to include knowledge related to the client's cultural background and concepts related to transcultural nursing. Since then, professionals have identified some of the knowledge and skills required in order to provide culturally sensitive care, yet a lack of cultural knowledge remains one of the most commonly cited obstacles to providing this care (Murphy & Clarke, 1993). Sharma (1988) found that of nurses she surveyed, 98% said they needed more information related to their client's culture to enable them to provide culturally sensitive care.

Lynam (1992) outlined principles for fulfilling educational needs of nurses to enable them to undertake the process of negotiation with all clients. A balance of ethnospecific knowledge, general concepts and strategies is needed to enable nurses to provide culturally sensitive care. Lynam (1992) advocated that nurses be aware of their own culture and belief system. Nurses must
have an appreciation for and be knowledgeable about the client's perspective. Communication skills to facilitate effective communication with clients must be learned, and an awareness of issues which affect the delivery of care to their clients must be encouraged. This knowledge and skills must be conveyed to practicing nurses, but literature which identifies nurses' awareness of these principles can not be located.

Theoretical and empirical knowledge related to culture and health has tended to focus on either the client's perspective of health and illness, and/or processes for applying the knowledge and skills needed in practice. One source of information related to the client's perspective is the wealth of anecdotal and descriptive literature devoted to describing and documenting the beliefs, values and health practices of diverse cultural groups (Fong, 1985; Lawson, 1990; Leininger, 1978; Lipson & Meleis, 1985; Louie, 1985; Spector, 1991; Waxler-Morrison, Anderson & Richardson, 1990; Wilkins, 1993). As Lynam (1992) has argued there is variation within cultural groups, so to limit our knowledge to such information can lead to cultural stereotyping. Instead, she argues, ethnospecific knowledge must be balanced with knowledge of concepts and processes that enable the provision of culturally
appropriate care for all clients.

Recently, researchers have begun to investigate the client's perspective in an effort to provide an understanding of their experience for health care professionals. A number of studies based on Kleinman's work illuminated the clients' perspective, and elicited their explanatory model of illness events. Struser (1985) found that Indo-Canadian women in her study frequently felt ignored by nurses in the post-partum period. A phenomenological approach was used to interview eight Indo-Canadian women to elicit their explanatory models of their child-bearing experiences. The women's experiences were strongly influenced by social context, and were affected by such factors as acculturation and English fluency. All eight women perceived discrimination by the nurses, felt ignored, and felt that this negatively affected the nursing care they received. Providing nurses with similar information related to their clients' perspectives would greatly assist them in understanding their experiences and providing care.

In 1982, Anderson and Chung conducted a phenomenological study to obtain families' perceptions of their child's chronic health problems. Seven white families and six Chinese-Canadian families were interviewed. Findings indicated that the Chinese-Canadian
families had a different world view from the white families and health care professionals. There were different priorities for care between the health professionals and Chinese-Canadian families. The Chinese-Canadian families' expectations often conflicted with those of the professionals. This study was important in emphasizing the need for health care professionals to be cognizant of their client's perspective, and reinforced the need for professionals to negotiate with their client to provide mutually agreeable goals for care.

Communication problems with clients and their families were frequently cited as a source of difficulty for nurses (Murphy & Clarke, 1993; Rader, 1988). Barriers to effective communication were as much cultural as they were linguistic. Communication difficulties can arise between the client and nurse who share a common cultural background, since, as Kleinman (1978) indicates, laypeople and practitioners often have different explanatory models. As communication is a process of presenting and receiving information, there is a need to have ongoing dialogue to ensure intended messages are heard and to clarify misunderstandings. Kleinman's (1978) conceptualization of explanatory models has made explicit how culture shapes the way meanings are assigned and experiences conceptualized. Cooperation in treatment can
be increased when the nurse and family attach the same meaning to the words they share (Anderson, 1985).

A number of tools and models have been developed to facilitate the process of negotiation between client and nurse, and which enable nurses to provide culturally appropriate care (Fong, 1985; Kleinman, Eisenberg & Good, 1978; Tripp-Reimer, Brink & Saunders, 1984). This literature focuses on providing direction for the nurse to elicit the client's perspective and to begin the process of negotiation with the client regardless of his or her cultural background. After an extensive search, research which examined the nurses' use of these models in practice could not be located.

Institutional Supports to Overcome Barriers

The issues involved for nurses must be examined in conjunction with the agency in which the nurses work. As Louie (1985) indicated, there is a paucity of literature which examines the organizational settings and their impact on the nurses' ability to provide culturally appropriate care.

The health care institution, by its philosophy and management, affects the nurses' ability to provide care to all clients (Harris & Tuck, 1992). Factors such as workload, acuity, inservice education and availability of interpreter services are controlled primarily by the
resources of the institution. Hospitals are cultural institutions that are the working domain of health care professionals. It is necessary to appraise the extent to which they create a climate in which culturally sensitive care can occur.

A number of institutional supports have been identified which facilitate the nurses' ability to overcome barriers to culturally sensitive care. Supports such as philosophical support, interpreter services and educational programs have been proposed by various authors (Harris & Tuck, 1992; Malone, 1993; Rader, 1988).

The ability to provide culturally sensitive care does not occur spontaneously nor individually, it requires encouragement, philosophical support and skills (Harris & Tuck, 1992). There is a role for the agency in fostering an environment in which nurses may apply their knowledge and skills to optimize care. Harris and Tuck (1992) outlined aspects of implementing culturally sensitive care in an agency which they suggest must begin with philosophical commitment. Since the values inherent in the philosophy of an institution affect decision making at every level, it is vital that the philosophy reflect the importance of culturally sensitive care. Harris and Tuck (1992) further suggest that nursing staff must have the necessary skills and educational
opportunities to provide culturally sensitive care. They suggest inservice education as a means of updating basic nursing education, and add that the time needed to acquire knowledge should be part of the job, not considered personal time. Harris and Tuck (1992) argue there must be a balance between commitment to the community, and fiscal restraint. In light of their previous suggestion related to inservice education, they did not suggest how this may be accomplished. Harris and Tuck's (1992) paper did not address resources nurses are currently using to provide care to culturally diverse clients.

Malone (1993) discussed the role of the agency in providing culturally sensitive care from an administrative perspective. Malone advocated hiring more culturally diverse staff to help provide care, and proposed incorporating a cultural awareness component in staff evaluations as means of increasing the delivery of culturally responsive care. Malone did not propose specific ways of ensuring staff had the education and resources they needed to provide care and to become more culturally sensitive. Direction for providing practical support for nurses was not addressed. Malone did note that budgetary concerns were never far from any hospital's strategic plan. From an administrative point
of view, it would seem that fiscal restraint was of primary concern, and finding ways of reducing costs while maintaining a high standard of care would be valuable.

A survey conducted by the Social Planning Council of Toronto (Doyle & Visano, 1987) identified higher costs related to care of ethnocultural minorities. These costs included: readmissions to hospital due to inadequate teaching or lack of patient understanding of the nature of the illness; increased number of tests necessary due to an inability to obtain a complete history; extended hospital stays, and time lost waiting for interpreter services to be organized. The survey examined access to mainstream health and social services for members of ethnocultural minority groups from the perspective of the community organizations. The survey illustrated the costs involved in not providing culturally appropriate care.

Specific issues for nurses, and the resources they may have used were not identified, nor were concrete guidelines for institutions presented. The authors suggested social policy changes, and resources such as greater education about the health care system for the ethnocultural communities. It was noted in a brief addendum that few community agencies had implemented the suggested changes due to costs involved upfront. Research which examined the difference between capital outlay of
funds to initiate culturally sensitive care, and the long-term costs of not providing appropriate care could not be located.

Some tangible resources have been identified to assist in providing culturally sensitive care. A frequently cited obstacle to providing health care is a language barrier (Murphy & Clarke, 1993; Rader, 1988). Many hospitals have a system of interpreters in place to assist staff in providing care, yet several studies report these services to be inadequate (Lynam, Sauro et al., 1991; Rader, 1988).

In 1988, Rader conducted a needs assessment to quantify her agency's need for a formal interpreter service and justify the cost of the service. Rader's researcher-designed questionnaire found that the use of interpreters was often unsatisfactory and inappropriate both at a superficial level to orient clients, and at a more complex level for teaching and consent signing. Rader (1988) found that nursing staff from similar ethnocultural backgrounds were often called upon to interpret for patients other than their own, which was very time consuming. Fifty percent of the interpretation was provided by nurses and physicians, with non-professional hospital staff and client's families being used for the remainder. Rader noted that nursing staff
spent time away from their own duties, and housekeeping staff often did not have the medical knowledge needed to provide a complete interpretation. Clients often did not want friends interpreting sensitive confidential information, and as a result had to delay treatment until an interpreter outside the family could be arranged.

Rader's (1988) needs assessment can not be generalized beyond her own outpatient clinic. It was valuable in documenting the need for trained interpreters, and in identifying the effect on nursing services when interpreter services were unavailable. Rader explored some important issues about the appropriateness of informal interpretation. Health care agencies assume that the need for interpretation will be met by an individual who speaks both languages. However, it can be argued such a person may not be skilled in cultural interpretation, and may be unable to elicit the cultural meaning of the conversation or convey the professionals' meaning to the client. Both Rader (1988) and Murphy and Clark (1993) found in many instances family interpreters were used. It can be argued the gender and/or age of a family-provided interpreter is inappropriate. For example, families may find themselves relying on a child to interpret important information or to facilitate a discussion of sensitive, personal issues.
Stevens (1993) cited the case of a woman who nearly had an unwanted abortion as a result of miscommunication through her small child's efforts to interpret. The client's confidentiality can not be assured if untrained staff are used to interpret, and the implications of uninformed consent are far-reaching. Literature which addressed the utility of other institutional supports such as written material to bridge the communication gap can not be located.

**Literature Summary**

The review of the literature has discussed two major theoretical perspectives from which to view the process of providing culturally sensitive care. Kleinman's (1978) explanatory model of health has been chosen as the conceptual framework for this study.

A review of the literature demonstrated that caring for culturally diverse clients is often a difficult and stressful process for nurses. Some issues encountered by nurses such as communication problems and frustration have been identified. As yet, the experience of paediatric nurses caring for culturally diverse clients remains undocumented. Specific attributes of paediatric settings such as the complex role of the nurse, and the involvement of parents in basic care of their child have been identified.
There is a paucity of literature which provides concrete direction for nurses and agencies to support culturally sensitive care. A review of literature outlining the knowledge and skills needed by nurses to provide culturally sensitive care reveals a wealth of knowledge and skills needed. A review of institutional supports reveals a dearth of literature which indicates specific direction for supporting nurses in providing optimal care. Some concrete supports such as interpreter services have been discussed.

In light of the current state of knowledge related to culturally sensitive care, some questions can be raised. Are nurses adequately prepared for caring in a multicultural setting? Do they possess the knowledge and skills necessary to negotiate appropriate goals for care with their clients? It has been suggested that support for culturally sensitive care must come from the institutions, bearing in mind that costs must be contained. What is meant by support remains unclear. Is it philosophical or more tangible direction? If the nurses are able to identify the needs of their clients, to what extent does the agency provide resources to enable them to meet those needs? This study sought to identify the issues nurses identified and described when providing care to culturally diverse clients. The second
aspect of this study was to identify the resources and supports nurses needed to provide efficient, client-centred care in a culturally diverse paediatric setting.
CHAPTER THREE
METHODS

Research Design

In this study, a descriptive research methodology was used to identify and describe the issues affecting paediatric nurses' ability to provide culturally appropriate care. The resources which facilitate or hinder this care were examined. Descriptive research provides a portrayal of an individual, situation or group to discover new meaning, describe what exists, determine the frequency with which something occurs, and identify relationships without establishing causality (Burns & Grove, 1987). This design was congruent with the purpose of the study and was appropriate for investigating a topic about which little is known.

Instrument

A questionnaire was developed by Lynam, Sauro et al. in 1991 to identify the issues for nurses who cared for multicultural clients (See Appendix A). This questionnaire, the NMS-INR, was used for the current study to identify the issues nurses report in caring for paediatric clients whose cultural backgrounds differed from the nurses'. The NMS-INR, required that participants respond to a number of fixed-response questions, frequency assessments and open-ended questions concerning
their experiences caring for clients of different cultural backgrounds. Demographic information was also gathered to describe the participants. Following development of the questionnaire by Lynam, Sauro et al., it was submitted to a panel of expert nurses who critiqued it for face validity and content validity. Appropriate changes were made based on the panel's recommendations. The questionnaire was then pilot tested with nurses working in adult community hospitals. Using feedback from the participants, a number of questions were reworded or broken into two questions (see for example, question #34).

Minor revisions concerning grammar and sentence structure were added by this investigator. Several questions related to age and gender of the adult clients were deleted as they were deemed irrelevant for this study. Questions related to the size of the agency were left in, as it was not known whether two or more agencies would be accessed in order to obtain sufficient responses for this study. The final open-ended question was divided to include the nurses' descriptions of successful and difficult experiences caring for families from other cultures.

Questions 1-9 were related to demographic information and educational background of the nurses in
order to describe the sample. Questions 10-16 dealt with the setting size and staffing formats. The subsequent fixed-response and open-ended questions arose from the literature related to the knowledge and skills needed by the nurses, and the agency resources suggested to support culturally sensitive care (Harris & Tuck, 1992; Malone, 1993; Spector, 1991; Waxler-Morrison et al, 1990). Questions 17-20 examined the nurse's knowledge of the ethnocultural groups in the community, and elicited their knowledge sources related to these groups. Questions 31-33 assessed the agency resources available to provide the nurses with the knowledge and educational support they might draw upon in order to be more culturally aware. The nurse's use of resources such as texts related to cultural perspectives of clients, educational opportunities for nurses, and resource people were sought. Questions 21-30 examined the nurse's use of available resources to facilitate communication with clients. A Likert scale format was employed to rank the use of resources for interpretation such as family members, staff or trained interpreters, and to identify who was responsible for organizing interpreter services.

Questions 34-35 asked for the nurses' experiences, both successful and unsuccessful in caring for clients from another culture. It was anticipated that the
responses to the open-ended questions, following content analysis, would identify the issues which arose, and the resources nurses utilized to address the issues. The final two questions solicited the nurses' suggestions for resources or supports they would like to have available, and provided respondents with an opportunity to add further comments.

Following the changes, the investigator submitted the questionnaire to the thesis committee for review to ensure face validity and clarity. The instrument was then pilot tested among paediatric nurses to assess clarity. Based on the pilot test, the wording of several questions was changed, and question 19 was split to include 'most' and 'least' knowledgeable.

Reliability is the extent to which one will get the same answers from similar populations using the same questionnaire (Woods & Catanzaro, 1988). This was addressed through the use of a pilot study. Responses similar to those found by Lynam, Sauro et al., (1991) were obtained. Some differences congruent with the different population were noted such as issues related to parenting behaviours. The current study contributed to the reliability of the questionnaire by applying it to a population with different characteristics from the original sample.
Participant Selection Criteria

The participants were nurses registered with the Registered Nurses' Association of British Columbia, employed in a paediatric setting. They must have worked on the unit for at least one year to ensure they were comfortable with their role and the agency, and to increase the likelihood that they had cared for a client from another culture. Participants could be employed full-time, part-time or on a casual basis. They could be male or female and from any ethnocultural background. Participants had to be fluent in English to ensure they could respond to the questionnaire.

Protection of human rights

To ensure that the human rights of the participants were protected, the study met the criteria set forth by the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects, and the British Columbia Children's Hospital Review Committee for Research Proposals.

The participants were given both verbal and written information about the study (see Appendices C & D), as many participants often have difficulty remembering the full details of an agreement (Woods & Catanzaro, 1988). Consent to participate in the study was implied by the
completion of the questionnaire. Participants were made aware of the length of time the questionnaire would take to complete (approximately 30-45 minutes), and that they would not be identified in any way. Questionnaires were numbered to ensure confidentiality. Nurses were informed that declining to participate in the study would in no way affect their employment status with the hospital.

**Sample Selection**

A convenience sample of 42 paediatric nurses was selected from B.C. Children's Hospital (BCCH). Convenience sampling, a form of non-probability sampling is appropriate to a study of this nature (Burns & Grove, 1987). Paediatric nurses who had cared for a child and family whose culture was different from their own and who met the selection criteria were encouraged to participate.

**Sample Recruitment**

Following the approval of the University of British Columbia Ethics Committee and the research ethics committee of British Columbia Children's Hospital, sample recruitment commenced. A letter of introduction was given to each of nine head nurses (see Appendix B). One head nurse discouraged access to her staff due to overwhelming study participation in recent months. This unit was not included in the study. The investigator met with staff of
the other patient care areas to explain the nature and purpose of the study, and solicit volunteers to participate in the study. A letter of information was placed in the communication book on each module inviting other participants (see Appendix C). Questionnaires (Appendix A) and a letter of information (Appendix D) were passed out in individual envelopes to interested nurses at each unit meeting.

Data Collection

The envelopes were sealed by the participants following completion of the questionnaire, placed in an envelope on the unit, and collected by the investigator twice a week. Several follow-up meetings with staff were necessary to obtain a sufficient number of responses. Data collection, from subject recruitment to final response collection took 5 weeks.

Response Rate

A total of 42 out of the 105 questionnaires distributed were returned, a response rate of 40%. Of these 42, approximately half completed the open-ended questions on the last three pages of the questionnaire. The poor completion rate may be related to several factors. The nurses were told the questionnaire would take approximately 30-45 minutes to complete. The first 33 questions could be quickly answered, and the last few
took more time and effort. Many respondents may have been unable to recall a particular situation or did not recognize the value of their experiences. This trend was recognized half-way through data collection, and during follow-up meetings with staff to obtain further questionnaires, the value of the last three questions was emphasized, and the completion rate for these questions did increase.

Data Analysis

Demographic data were analyzed using descriptive statistics such as percentages and averages in order to describe the sample. The answers to the fixed-response questions were summarized. Where applicable, percentages were calculated (see for example questions 17, 22 & 26). The Likert-scale ranking questions indicating interpreter use were summarized and a chart developed to illustrate the results (See Figures 2 & 3).

Content analysis was performed on the open-ended questions. Content analysis is a systematic procedure used to identify and analyse written or verbal data in order to classify and summarize the data (Seaman, 1987). It is a method of creating structure from unstructured data. Field and Morse (1985) describe two forms of content analysis. Latent content analysis views passages or paragraphs within the context of the whole to identify
the major thrust of the piece. Manifest content analysis uses descriptive statistics to illustrate the frequency with which each theme appears. Both of these approaches were used.

The investigator reviewed the responses to the open-ended questions eliciting the nurses' experiences several times, and identified themes which captured the essence of the responses. Common themes were then grouped into categories, and criteria for each were determined. Many nurses did not describe a specific situation in which they provided care to a client from a different cultural background. They did however, describe some issues which affected their care in the space provided for additional comments. It was decided to include the respondents' comments as data pertinent to the first research question, along with both the successful and unsuccessful situations described. It is from the analysis of these three sources that the issue of communication was identified.

Communication emerged as the overriding issue for nurses, and the themes were manifestations of the effect a communication barrier had on different aspects of the nursing process and on the nurses themselves.

Two categories emerged related to providing care: Assessment and The Process of Providing Care. The
category of assessment encompassed themes of urgency and the nature of the information to be assessed. The aspects of providing care which were most affected when there was a language barrier were: providing support, teaching clients and families, and conveying information seen as crucial, to families.

The category of Consequences for Nurses encompassed two themes related to the nurses' experiences when they were unable to provide optimal care. In such situations, nurses felt frustration and experienced moral and ethical dilemmas. A comparison between successful and unsuccessful situations revealed three factors which influenced the nurses' success in managing care. This category of Influences on Practice included: the nurses' personal philosophy, the nurses' perceptions of resources which were available, and availability of interpreter services.

The themes were reviewed and rearranged several times prior to the final organizational framework. Two other individuals were asked to categorize the responses. Interrater reliabilities were 78% and 82% for the themes identified.

Summary

A descriptive approach was used to respond to the research questions. A questionnaire, the NMS-INR
developed and pilot tested by Lynam, Sauro et al., (1991) was used. A convenience sample of 42 nurses was recruited at British Columbia Children's Hospital following the approval of the Ethics committee. Ethical considerations reflected the protection of human rights. Data collection occurred following distribution of the questionnaire to volunteers. A response rate of 40% was obtained. Data analysis was conducted using descriptive statistics, and content analysis as described by Field and Morse (1985). Presentation and discussion of the study findings appears in Chapter 4.
CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

This chapter is organized into four sections. The first section presents a description of the setting and participants. The second section presents the findings related to the first research question; what issues do nurses identify as influencing their ability to provide culturally sensitive care in a paediatric setting? The third section presents findings related to the second research question; what agency-based resources facilitate or hinder the nurses' ability to provide culturally sensitive care? The final section presents a discussion of the findings.

Description of the Setting and Participants

The paediatric setting used was a 236 bed tertiary care centre. Eight inpatient care units or Modules, the 24-hour Emergency Department, and the Special Care Nursery were accessed for the study. Patient acuity often changed staffing patterns, but during this study there were 5-10 nurses per shift on the Modules, 1-4 in Emergency, and 16-20 in the Special Care Nursery.

The sample consisted of 42 paediatric staff nurses. Thirty-one participants were from the patient care
Modules, 6 were from the Emergency Department, and 5 worked in the Special Care Nursery (SCN).

Ninety percent of the sample were female, and ten percent were male. The statistics for the Registered Nurses' Association of British Columbia (R.N.A.B.C.) in 1993 indicated that 97% of nurses were female and 3% were male. Thus there was a slightly higher percentage of males among the respondents for this study. Although males were among the participants, this paper will refer to all respondents as 'she', the 'nurse' or the 'respondent' to ensure confidentiality.

The respondents' ages ranged from 20-55, with the largest group (43%), falling between 26-35 years of age. In 1993, 28% of B.C. nurses were in the 25-34 year age group. There was a slightly higher percentage of younger nurses in this sample than in the B.C. population.

In the sample population, 74% were diploma nurses, and 21% were degree prepared. Five percent had higher education in other fields such as a Bachelor of Arts. The R.N.A.B.C. statistics (1993) indicated that 15% of nurses were degree prepared, and 83% were diploma graduates.

Forty-five percent of the participants have been employed for ten or more years. The second largest group (33%) had five to ten years experience. The remainder (22%) had been employed between one and five years. As
outlined in the selection criteria for the sample, no participant had less than one year of experience.

The R.N.A.B.C. statistics (1993) indicated that 55% of nurses in the province are employed full-time, 25% have casual employment and 19% are part-time. The sample in this study differed in that 64% of the respondents worked full-time, 23% were part-time and 12% were casually employed nurses. The difference may have been related to the method of distribution of the questionnaires. The flexibility provided by casual employment allows many nurses to work nights and weekends and by accessing the wards during daytime and evening hours during the week, casual nurses may have been missed.

Fourteen percent (6) of the participants spoke a language other than English, the remainder were unilingual English speaking. The other languages spoken included Chinese, French, and German.

The findings indicated that a convenience sampling technique resulted in nurses who were fairly representative of B.C.'s nursing population in terms of age, gender and educational background.

Following the description of the methods employed in Chapter 3, the major findings will be presented in relation to the research questions.
Findings Related to the First Research Question

Issues Related to Communication

Communication was the overriding issue which affected the nurse's ability to provide care in a culturally diverse paediatric setting. The communication barrier affected the nurse's ability to assess her client thoroughly. Aspects of providing care that were most affected by a communication barrier were: teaching, providing support and conveying crucial information to the client's family. The inability to provide optimal care had serious consequences for the nurses. Many nurses indicated they experienced frustration, and described moral and ethical dilemmas associated with the inability to provide optimal care.

In more than half of the situations reported, nurses were able to access and use resources to enable them to overcome communication problems and provide optimal care. The problems were overcome when nurses had a personal philosophy which valued differences among clients and enabled the nurse to individualize care. Agency resources such as interpreters were also needed to ensure open communication. A discussion of the specific resources and supports used by the nurses will follow in response to the second research question.
The family-centred care philosophy usually held by paediatric nurses was evident from the responses of nurses in this sample in that all of the participants described situations including the parents and family members rather than just the child. None of the nurses described situations in which they had been unable to communicate with the children themselves. Most of the communication difficulties described arose between the nurses and the families. The researcher speculates that most of the children were immersed in English at school and were therefore intermediaries for their parents, or they were infants and other means of communication and nurturing were used.

The categories and themes will now be presented using examples from the nurses' responses. In some instances, minor editing of responses has been done to enhance comprehension.

Assessment of the Client

Assessment is essential to the provision of care, and nurses must gather data related to the whole client. For the study respondents, assessment provided the basis for planning and implementing care, and was dependent upon the effectiveness of mutual communication. Issues related to assessment were grouped according to the urgency of the situation, and the nature of the
information needed.

Urgency of Situation

The importance of communication was magnified in situations deemed to be more urgent, such as during admissions, or in emergency situations, where the direction for nursing care evolved from a rapid, thorough patient assessment. One nurse emphasized the need for more interpreters during peak admission times:

We need more interpreters available for admissions. It is critical then to obtain information and do an assessment.

Respondents wrote that arranging for an interpreter took at least 24 hours, and that they needed to communicate immediately with their clients. One emergency room nurse wrote that valuable time was lost organizing an interpreter:

We need more available interpreters. Sometimes it is too late by the time a meeting is arranged.

Nature of the information

The nurses' need to communicate effectively was also influenced by the nature of the information to be assessed. Obtaining patient histories, assessing responses of clients and families to new information (i.e. diagnoses) or situations (i.e. death, admission to hospital), and assessments of cultural meanings are three
types of information. None of the nurses described situations in which the nature of the information to be assessed included a physical assessment of a child.

Complete patient history

The need to communicate effectively in order to obtain a complete patient history, arose particularly among Emergency room nurses, as a complete patient history provided the basis from which subsequent diagnosis and treatment plans were developed.

One Emergency room nurse described a situation in which an understanding of the precipitating factors in the exacerbation of a chronic illness was needed to provide direction for treatment.

A Vietnamese family brings their chronically ill child in. Due to a language barrier, we are unable to get a complete history.

Nurses on the inpatient units described similar difficulties with admissions. One respondent wanted advance notice of admissions if language was anticipated to be a problem, so an interpreter could be made available. This would enable her to get important basic information from the family to complete an assessment.

Assessing the client and family's response

Nurses also reported difficulties in appraising the client's and family's response to a new diagnosis,
treatment regimen, or situation when a language barrier existed. An assessment of psychosocial and emotional needs provided a basis for supporting and teaching clients and families. The participants did not describe situations in which they appraised solely the child's response. Their descriptions concentrated primarily on the parents and family members.

The importance of assessing the response of the family to certain situations was illustrated by the following nurse who described the experience of having a doctor briefly interpret for the family of a critically ill infant. The participant observed that the doctor was able to convey the facts of the child's illness to the parents. The nurse, however, was unable to determine if he explored their feelings related to the situation, or discussed the supports the family might have needed. This created a set of difficulties for the nurse, and was a source of frustration for her. She was unable to support this family without knowledge of their feelings or level of comprehension of the critical situation.

I wanted the family to know how ill the baby was, but was unsure whether the doctor passed this on. Mom had a very flat affect, and Dad seemed inappropriately pleased. I read the chart thoroughly to find there was little or nil documentation about what was said to parents.

Another nurse had a similar experience with a family who
spoke English, but whose culture was unfamiliar to her. She was unable to assess the family's reaction to a diagnosis of their child's serious condition from their non-verbal cues:

I felt very uncomfortable because their interaction was minimal. The family was quiet and answered in a closed manner to my open-ended questions. I was concerned that the family was not happy with my care, and that I was not being supportive.

The previous two situations illustrated the central role of communication in assessment and the provision of care. Nurses had difficulties with language and with assessing the client's perspective on the care situation. The communication difficulties were further compounded because they did not know what meanings to assign to the parent's behaviours. In neither of the above situations were the respondents successful in assessing non-verbal cues to behaviour.

Appraisal of cultural meanings

Communication difficulties also affected the nurses' ability to appraise the cultural meanings of illness of their clients and therefore interfered with the nurses' being able to fully assess the client. As Kleinman (1978) argues, a client's view of health and illness differs from that of the health care professional. The provision of culturally sensitive care in this framework therefore
requires the professional to seek to understand the clients' cultural perspective, and their personal and social experience of illness (Anderson, 1987). An inability of respondents in this study to communicate and elicit the client's perspective can be seen as negatively influencing the provision of care.

One participant described an incident which was resolved because she was able to elicit information related to certain cultural practices from her client, and incorporate this into her care of the family.

Mum was breastfeeding. Family was admitted to a 2-bed room with another patient, an 8 year old boy. Father became very upset, insisting on a single room without stating reasons for request. His minimal English deteriorated as he got more upset. Mother started crying and grandmother was talking loudly in native language to me. By taking father into the office, eventually he calmed down enough for me to learn that as the 8-year old was very mature looking for his age, they assumed he was an adolescent male, and he could not leave his wife with another ‘man' sleeping in the same room. Conflict was resolved by moving mum and baby to a 4-bed babies room. Father and family were much happier.

A number of respondents expressed difficulty understanding the parenting behaviours they were encountering. Family structure and roles are determined by culture and social context (Anderson, 1987). As the result of communication difficulties, respondents were unable to elicit explanations for behaviours they observed.
One nurse described a situation in which the parent's actions were not understood, and the language barrier prevented the nurse from eliciting the parent's meaning of their behaviours;

The parents... spoke no English and didn't use the conventional American ways to care for their twins.

The nurse was concerned that the babies' care was compromised and enlisted the help of a social worker, nurse clinician, and an interpreter in assessing the care. The outcome of this situation was not revealed by the nurse. Whether this situation was a misinterpretation of childrearing practices or one in which the children were actually at risk is not known. What is evident, however, is that the provision of nursing care is an ongoing process of action and reappraisal. When nurses have difficulty assessing the impact of an event or their own actions, they may draw conclusions about parenting, needs for information or adequacy of care that are inaccurate.

Ineffective communication occasionally lead to respondents drawing erroneous conclusions about their clients based on incomplete assessments or misunderstandings of observations. Respondents perceived clients to be non-compliant and formed judgements about
them when they did not meet expected behaviours or when respondents were unable to elicit an explanation for behaviours.

One nurse described a mother as non-compliant when she refused to give her son his medication because the child didn't want to take it. A language barrier affected the nurse's ability to elicit the mother's reasons for not encouraging her child to take the medicine. Communication also influenced the nurse's ability to provide the mother with valid information concerning the need for the medication.

Parents who bundled their febrile children were described by respondents as being non-compliant when the behaviour persisted after explanations had been given. One nurse described just such an experience:

A feverish child is bundled. I tried to explain why it's necessary for less clothing, and I turned around and they'd piled clothes and cloths on top of the child.

Nurses did not understand the client's reasons for their actions. They could not elicit from the parents their perceptions of treatment for fevers, they expended their energies in helping the parents understand how nurses and doctors treat fevers in children.

One respondent perceived her judgement of non-compliance to be based on her lack of understanding of
the client's culture:

The family was not compliant with treatment plan. I read up on their culture in a book available on the unit, and altered the care plan to fit the family's cultural beliefs. The family became more compliant.

This example demonstrated the change in perception which occurred when the nurse was able to incorporate knowledge of the family's culture into her care, but also that care is a negotiated concept. In the previous examples, the nurses were trying to ensure that parents understood the professional's perspective. In the latter case, the nurse sought to negotiate care between her professional view and the family's lay model.

Respondents reported that they needed much more information related to the client's culture in order to have a basic understanding of the client. Ten respondents wrote that if they understood the clients' culture they would have been able to provide better care. One nurse reported that an understanding of the client's culture would have provided her with a starting point from which to assess her client:

In many cultures, religion and religious beliefs are also a barrier. Resources of this kind would be helpful to staff to understand the parent's philosophy.

Another respondent wrote:

We need basic information on health issues in
cultures, such as death rituals, and parenting roles, so we can understand the reasons families act/do [sic] what they do with their children.

**Process of Providing Care**

The inability to communicate effectively influenced three main areas of nursing care: providing support and reassurance to the families, providing patient and family teaching, and providing information crucial to the care of the child.

In some situations, the impediment to providing care stemmed from the respondent's inability to fully assess the client. In other situations, the need for nursing care or intervention was clear to the respondent, but the communication barrier precluded this care.

**Supporting and Reassuring Parents**

Providing parents with support and reassurance throughout their child's hospitalization was an important role for the paediatric nurses, and one which they felt they were unable to accomplish when a language barrier existed.

This was particularly evident during stressful situations such as new admissions, and critical illnesses when parents needed support. One nurse described a situation in which she wanted to provide support when a newly admitted child was very ill;
I was concerned that I was not being supportive. The family was very anxious about hospitalization, having no idea... why he was here and what we were doing to him.

In this case the need for support to decrease the family's anxiety was clear to the respondent, but the communication barrier prevented her from implementing the plan of care for support.

Another nurse expressed satisfaction when she was able to provide support for a family in the face of a language barrier:

We used another staff member to translate an operative procedure to Chinese parents and I was able to support them emotionally through this translation.

In two cases, the need for support and reassurance was for a brief period surrounding a short procedure and non-verbal means of support were utilized. One nurse wrote that while waiting for medication to reduce a child's pain, she was unable to reassure the family that the child would feel better soon:

I've just tried doing sign language which didn't work too well, and waited until the medication acted.

A second respondent indicated that support and reassurance were provided during short procedures by smiling at the client's family:

Smiling helped lessen the tension. The family
perceived the nurse as an ally, friendly and concerned for them.

In the previously described situations, the need for supporting the parents was evident to the respondent. Less evident but no less important to respondents was the parent's need for ongoing support and reassurance during hospitalization, often for a period of days or weeks.

One participant described a situation which illustrated her awareness of the importance of providing ongoing support to parents during hospitalization:

I cared for a baby and his parents who spoke Chinese only. I was unable to effectively communicate. The baby was eventually discharged and I was able to have a nurse from another unit translate briefly for me. I did not feel that this family was given enough information and support due to the communication barrier during their entire stay.

The need for continual support and reassurance of parents when a child is hospitalized was emphasized by two respondents who described the daily frustration they encountered:

There are always questions and concerns that the family tries to relay to us that we do not understand.

It is hard. We are unable to console parents when they are upset.

For these nurses it was the daily interaction and support of parents which was important to them.
Providing support and reassurance to foster the parent's involvement in daily care of the child was a challenge for the participants. Some of the respondents were able to encourage tangible forms of support for parents despite the communication barrier. Some respondents encouraged parents to bring in religious symbols and foods from home to foster a supportive and reassuring environment for the child.

**Teaching**

A second aspect of the provision of care was teaching. Communication difficulties affected the nurses' ability to provide patient and family teaching in both urgent and anticipated situations. In all of the situations related to this theme, respondents had inferred from the situational context a need to provide client and family teaching.

The urgency of admissions and new diagnoses presented specific challenges to the nurses. One respondent described a family with a newly diagnosed child for whom she was unable to provide immediate information:

A child whose family only spoke Punjabi and we had to teach them about treatment options in renal disease. We could not find any information in Punjabi, and the translator needed 24 hours notice.

In this case, the inability to communicate affected the
delivery of the information itself to the child and family.

One nurse described a situation in which the need for an interpreter could have been anticipated:

An East Indian family taking home an infant after a long stay as he was premature. Only on the second to last day did we discover mom had yet to do a baby bath and could not read infant cues. Obviously very little teaching had been done.

Nurses then had to arrange for rooming in and the baby had to stay an extra few days so appropriate teaching could occur. In this case, a communication barrier had hindered the respondent's ability to assess that this mother needed teaching. Once the need had been identified, it then took some time to organize the appropriate resources and provide teaching, and the length of hospitalization was extended.

Another family required discharge teaching for management of renal disease, and no family member was available to interpret. The child had to stay in hospital an extra day while the nurses arranged for a professional interpreter.

Even in situations in which planning ahead was done, teaching was difficult for staff. One nurse underscored the need for a trained interpreter by stating:

Teaching is very difficult when the patient is from another culture. The use of an interpreter
who understands both cultures is necessary to help with discharge teaching.

Conveying Crucial Information

The third aspect of the provision of care encompassed situations in which obtaining consents and ensuring safety of the child were described.

Providing the parents with enough information and support to enable them to give an informed consent was a particularly disturbing problem described by respondents. Three respondents described situations in which obtaining consent was complicated. In one situation, a child interpreted for his parents for the purposes of obtaining consent for his own surgery. One respondent described a pre-operative patient whose family did not understand English. The doctor obtained consent despite the language barrier. Neither instance documented the use of an interpreter.

For some respondents, their inability to communicate important information to parents resulted in threats to the safety of the child. One participant described an incident in which she was unable to convey to the mother the importance of not disturbing her child's operative site. The result could have seriously injured the child:

Mom was trying to feed the baby hard foods immediately after a cleft palate repair.
The parent was providing basic care, but lacked crucial information in order to do so safely.

Other respondents described the repeated bundling of febrile children by their parents and grandparents, which increased their temperatures. Febrile seizures are common in the paediatric population, and prompt reduction in temperature is a vital part of patient care (Hazinski, 1984).

Threats to the safety of other children were a potential problem because the participants were unable to communicate important concepts in care to parents. One nurse described a family repeatedly breaking strict isolation procedures and visiting policies. On the respondent's ward both policies were very important for decreasing the spread of infection. This placed the client and others at risk for infection.

The concept of communication, as developed in the preceding sections, points to the reciprocal nature of communication. Nurses and parents were restricted in their ability to participate in a dialogue about a myriad of care issues. The next section addresses how these communication difficulties shaped the nurse's experiences of caregiving.

**Consequences for Nurses**

Difficulties arose for the nurses when they were
unable to communicate effectively with their clients and families for the purposes of appraising them or providing optimal care. These difficulties manifested themselves as frustration and moral and ethical dilemmas.

**Frustration**

The frustration of not being able to communicate effectively with clients was expressed by the respondents. For some respondents, frustration was heightened by stressful or urgent situations. Some nurses described the source of frustration as being the inability to assess the client. Others were frustrated with the inability to provide optimal care. One respondent described a situation in which the communication barrier interfered with her ability to assess her client's family's emotional state and provide appropriate support. A child who had been involved in a motor vehicle accident was admitted with a head injury. Her mother had been the driver. The father spoke limited English, and the child's mother spoke none:

The father appeared non-communicative, and cross with the mother who was teary. Despite her wanting to stay with the child he took her home. Initially I was angry and frustrated at the father's response and wanted to intervene. The parents went home. I informed the social worker of my concerns. Eventually an interpreter was organized for the duration of admission to hospital.

This nurse was unable to assess the parent's knowledge
level of their child's injury, and their reactions to the incident. She did not understand the father's reasons for going home, especially since the mother wanted to stay. The respondent was also unable to provide them with support. Her frustration and anger at the situation were evident.

One informant described a child in obvious pain, for whom she felt the nurses were doing all they could. However, while waiting for analgesia to take effect, the family became increasingly agitated, and indicated the nurses were not doing anything for their child. This magnified what was already a stressful situation for the nurse involved:

We were trying our best, but could not communicate with the family. It was quite frustrating for us and for them.

This example also illustrated that nurses noted families shared their frustration with ineffective communication.

Another nurse wrote that frustration occurred almost daily during the ongoing process of caring in a culturally diverse setting:

Situations arise daily when I am trying to explain a procedure to a parent. It can be frustrating when the parent does not understand.

Several participants used words such as "difficult" and "frustrating" in describing different situations when a
language barrier prevented either assessment or providing care.

Moral and Ethical Dilemmas

Participants expressed distress with the dilemmas created by an inability to provide optimal care. They described situations in which they were aware of what they felt was right or what ought to be done, but were prevented from acting by the barrier of communication.

Providing the parents with enough information and support to enable them to give consent when a language barrier interfered, was a particularly disturbing problem for three respondents. The respondents indicated they were distressed by the knowledge that families may not have been fully informed prior to signing consent.

Nurses also found themselves in morally distressing contexts complicated by the language barrier. Two nurses described particularly difficult situations surrounding the death of a child. One nurse described an extremely premature infant who was not going to survive. The nurse was unable to ascertain whether parents understood the seriousness of the situation. In this situation there was much importance associated with the child being a first-born son for the family. The nurse also stated that several doctors had discussed discontinuing treatment with the family, but nothing was documented anywhere. The
nurse was unable to find out the family's reaction to the suggestion of discontinuing treatment. The nurse was also unable to assess the family's emotional state by observing them as she did not understand their non-verbal behaviours.

The experience of providing care to a dying child is a stressful event (Appleton, 1993). For the above respondent, the stress was heightened by the inability to ascertain the family's wishes or emotions concerning the impending death. The respondent felt she was unable to provide optimal support for this family during this crisis, resulting in a morally distressing situation for her.

In another situation a nurse described an Indo-Canadian child who was dying. In communicating with the family a female interpreter was used, but was apparently only conveying to the child's mother what the father wanted her to know:

It was extremely difficult, as we felt the parents should know everything. The doctors were finally able to get through to the father that the mum should know all the information. However, I feel that this may have upset the father, as in their culture, men make all the decisions.

The reaction of this nurse indicated she was distressed by the situation. Conflict between what the respondent felt her role as a nurse was (to inform the parents about
the child's condition) and her understanding of the family's cultural traditions created a complex moral situation for the respondent.

Respondents expressed distress at their inability to adequately provide ongoing support and reassurance for the child's family in the face of a language barrier. They felt this affected their roles as family-oriented paediatric nurses. One respondent, frustrated by the lack of family-oriented care for families from different cultures, wrote:

I am concerned that the mission for this hospital is family-oriented, but which family, white only? It is wrong to expect other cultures to fit into the white 2-parent family norm. It is disrespectful. How then can we build trust and support [with these families]?

Respondents also found it troubling when their inability to provide optimal care resulted in threats to the safety of the child. As previously illustrated, the inability to obtain a complete patient history affected the nurses' ability to provide optimal care. Potential harm to a child could have resulted if vital information exchange did not occur. This was reported more frequently by nurses from the Emergency ward, where a patient history was a crucial aspect of care. As a previously described situation of a chronically
ill Vietnamese child repeatedly admitted to hospital indicated, if vital information was missed, the child could suffer harm or delayed treatment. Knowledge of the precipitating factors in a chronic illness was vital to planning and providing care.

Influences on Practice

There were a number of situations in which the respondents reported they were successful in providing care. In these instances, there were three influencing characteristics: the nurse's personal philosophy; the availability and utility of interpreters; and the availability and use of other resources. The availability and use of both interpreter services and resources will be discussed in depth in response to the second research question. What follows here are respondents descriptions of the resolution of difficulties when all three characteristics, personal philosophy, interpreters and resources came together.

Personal Philosophy - Valuing Different Perspectives

Difficulties were overcome when the nurses' personal philosophy valued differences among clients, and enabled her to seek out and access resources to work with those differences. Seven of the respondents indicated a personal philosophy which showed an awareness of the importance of cultural considerations
in providing care. One respondent indicated the diversity of each client was valued, and cautioned others against stereotyping clients based on their ethnocultural group:

It is vital that nurses not be tempted to make over-generalizations or ill-informed assumptions about different cultures. Not all individuals and families of a given ethnic group share the same values. A firm belief in our common humanity and respect for the dignity and diversity of all individuals and families, strong values in the nursing profession are our biggest assets.

Another respondent recognized commonalities between cultures:

Making an effort to be sensitive to the commonalities of human experience between cultures is very helpful in making nursing care easier. The hospital experience is stressful almost universally.

Both of these nurses had described situations in which they sought out and successfully used resources to address communication problems they had encountered.

There were other descriptions in which a respondent's philosophy valued the client's culture and enabled her to provide culturally sensitive care. One nurse, caring for an Orthodox Jewish patient who was to be hospitalized over the Sabbath made a great effort to accommodate the child and family:

Water jugs were made available as no taps could be turned on or off. IVAC pumps were placed on battery and lights were off in the patient's room as no electricity could be consumed, and special
meals were arranged through the dietician.

Other nurses who wrote they were aware of special dietary requirements for certain cultures, were able to accommodate the family's wishes. For example, one nurse allowed fish soup to be fed through a nasogastric tube and another nurse suggested special foods could be brought in for a child. The respondents indicated education related to cultural considerations played a role in their ability to provide culturally appropriate care in these instances.

For some respondents, their philosophy was such that they wanted to provide optimal care, but the absence of resources hindered them. Other respondent's philosophy was such that the inevitability of certain situations was accepted, and nothing was done to improve the situation. One respondent who faced a language barrier did not indicate the use of any resources:

You just can't talk some people out of thinking fevers cause brain damage anyway.

Interpretation - Enabling Open Communication

Interpreter availability and access was another factor which influenced the nurse's ability to provide care. One respondent identified the importance of
communication in implementing her philosophy:

Cultural problems can be overcome by open communication and willingness to adapt by all concerned. The biggest barrier is when language barrier is added to the cultural barrier. It is then that an interpreter is vital.

Several respondents indicated an awareness of the value of cultural considerations in care. They suggested that if they were able to communicate with their clients, they would be able to discuss the client's needs and provide them with more information related to their child's hospitalization.

Other nurses reported that when they were able to access an interpreter either a formal one or a staff member, they were able to address the client's concern, explain the illness or provide appropriate teaching. Respondents expressed satisfaction with this aspect of their care:

We were able to teach cast care because of the interpreter. [We also had] literature provided in the client's language.

One respondent's philosophy confirmed the centrality of language to nursing, and raised the issue of responsibility for ensuring the effectiveness of communication:

If people move to Canada they should realize they must learn to adapt to our culture. Learning one of our two national languages should be done before moving here. Therefore even if cultural
differences are still there, we could at least discuss and explain face to face.

This respondent felt it was the responsibility of the client to ensure communication was effective in health care. Responses to the second Research Question further illustrate the question of ownership of the responsibility for ensuring effective communication. The use of other resources to enable communication and enhance cultural awareness will also be addressed by the next section.
Findings Related to the Second Research Question

A language barrier, and a lack of knowledge related to the client's culture were two main issues identified in the literature which impeded the nurse's ability to provide culturally sensitive care (Murphy & Clark, 1993). The questionnaire elicited the nurse's use of agency-based resources to address these two issues. For organizational purposes, communication-related resources will be presented first, followed by resources used to enhance the nurse's cultural awareness. A discussion of these resources will then be incorporated in the discussion of overall study findings.

Resources Used to Address Communication Difficulties

Nurses reported using two groups of resources to overcome the difficulties presented by a language barrier: interpreters, and written resources. These will be addressed along with a discussion of how each affected the nurse's ability to provide care.

Interpreter Use

The use of interpreters was identified in response to the first research question as facilitating communication with clients. The respondents' use of interpreters, however, was related to their perceptions of the availability and cost of
interpreters, and their lack of experience working with them.

Nurses for the most part relied on family members for interpretation. The Likert scale responses related to interpreter use (Figure 2) illustrate the resources nurses used when they needed an interpreter. The client's family members were, for the most part, being used as interpreters, followed by other nursing staff. In the absence of family members most of the respondents felt that nursing staff were responsible for organizing formal interpreters (See Figure 3).

These results were reinforced by the nurses descriptions of their experiences. Most nurses were aware of how to access interpreters. Of the 42 respondents, 31 described situations in which they experienced difficulty communicating with their clients either for the purposes of assessment or to provide care. Of the 31 situations, six described using official interpreters. Other respondents described using hospital staff such as other nurses (7), housekeepers (3), doctors (2) and other unidentified staff who spoke the same language. Four of the respondents identified family members who provided interpretation. These included a hospitalized child himself and another client's family member.
Seven respondents used written resources to address a communication barrier.

Participants identified difficulties with the current interpreter system which hindered their success in using it. Difficulties included perceived availability of interpreters, and the perceived cost involved.
Figure 2. Types of Interpreters used in Practice

Percent of respondents reporting use

- trained interpreter with knowledge of medical terms
- trained interpreter with ability to provide cultural interpretation
- volunteer interpreter
- client's family members
- other nursing staff

Figure 3. Responsibility for Organizing Trained Interpreters

Percent of respondents reporting

- 1 never
- 2
- 3
- 4
- 5 always

nursing staff

family
Perceived Availability

The open-ended questions and comments section of the questionnaire provided much of the data supporting the nurses' reasons for not using interpreters. The reasons were related primarily to the urgency with which the interpreter was needed, and to the perceived availability of interpreters.

All but one respondent (98%) were aware of a formal interpreter service available within the hospital. When asked when respondents thought the interpreter services could be accessed, 45% reported interpretation was available 24 hours a day, 18% reported availability during office hours only, and 41% thought it depended on availability of personnel. These results indicate nurses' interpretation of the availability of services varied widely.

This was particularly evident for new admissions and in the Emergency department where urgency emerged as a theme related to the role of communication. One nurse's experience echoed that of many of her colleagues:

There is a number to call, however, I find it ineffective, because when an interpreter is needed, it is usually needed NOW.

Several nurses wrote they did not call an
interpreter because it was the weekend, or the evening and they perceived interpreter services to be unavailable. Several nurses wrote that it took too long to organize an interpreter (24 hours for a non-emergency) and it was easier to get a colleague to interpret. They did not indicate an awareness of the emergency interpreter.

Fourteen of the nurses described using professional and non-professional hospital staff as interpreters. This seemed to be related to the perceived availability of interpreters as well as the convenience of multilingual staff. Respondents stated it was easier to use staff than to access an interpreter:

It was a coincidence to have a staff person fluent in the language and who had nursing and medical knowledge.

Seven of the nurses' descriptions stated that other nursing staff were used as interpreters. As indicated earlier, some of the respondents were bilingual, but none of them indicated they had been called upon to interpret for a client. None of the respondents described experience with trained interpreters. Whether or not nurses found them knowledgeable and appropriate is not known. Whether or
not the nurses were comfortable working with interpreters is also not known.

Respondents reported using interpreters for anticipated events such as discharge teaching, and preoperative teaching. In these situations respondents indicated they were aware of interpreters available for those purposes. Respondents did not describe situations in which interpreters were used for providing ongoing support for families.

In order to ascertain what interpreter services were available to nurses in BCCH, brochures from the Patient and Family Education department were reviewed. Interpreter Services were in place in BCCH in January 1993, to address some language barriers identified through the ethnocultural survey conducted some years earlier (BCCH, 1990). Trained volunteers were available through the interpreter services during office hours. After hours emergency interpreters were available through AT&T Communications at a cost of $4.00 per minute. For sophisticated medical information, a paid professional interpreter was available on a limited budget. Ongoing family support was offered by connecting the family with a trained interpreter within the community. Brief guidelines for working with an interpreter were also provided in the
pamphlet. Despite these services made available by the agency, interpreters remain underused.

**Perceived Cost**

Respondents indicated an awareness of the cost of the AT&T emergency interpreter, and expressed reluctance to incur those costs. The investigator noted that the brochure sent to the nursing units advising them of the availability of interpreter services made mention of the cost of this service in two places.

**Use of other resources to address communication**

Resources such as written teaching materials and pamphlets have been identified as assisting with communication. The questionnaire elicited the respondents' awareness and use of available resources.

At BCCH there were a number of pamphlets, teaching aids and videos related to assorted disease processes and care management available in various languages such as Vietnamese, Chinese and Punjabi. Bedside translation aids and maps in four languages were also in use. These were developed in response to the recent ethnocultural survey (BCCH, 1990).

Ninety-three percent of respondents were aware of existing translated materials in the hospital, and most were aware of at least two types of resources
**Appropriateness of Resources**

Twelve participants (28%) responded that resources available were not appropriate for specific languages, teaching purposes, or disease processes. For example, cast care pamphlets were available in Punjabi, but fever management was not. Some nurses successfully adapted existing information to suit their client's needs. One nurse used a unit clerk who spoke Punjabi to translate an English video for her client's parents.

Twenty-eight nurses (66%) had seen key phrases in other languages posted in their hospital, but respondents did not express their experience with nor satisfaction with this method of communication. One respondent described experience with similar translation aids, but pointed out the difficulty with the different phonemes inherent in different languages.

In situations where written material was available and appropriate to both the language and situation, participants reported success in using them. Examples include cast care teaching to an Indo-Canadian family, and fever management information provided to a Chinese-Canadian family.

Seven of the nurses described using diagrams,
repetition, sign language, and the use of simple words to convey information to parents in the absence of appropriate literature for teaching. The effectiveness of these techniques is unknown, as the nurses themselves acknowledged;

   Basically I've just tried doing sign language with them, which of course did not work too well.

Another nurse described a technique she employed:

   I pointed to objects and repeated the same words many times.

Respondents indicated a need for more information to enable them to communicate with their clients. They requested more pamphlets available in different languages, and handouts indicating what was available. They also requested that the Family Resource Library remain open longer hours and on weekends to accommodate peak parent visiting hours. They suggested more interpreters be available in the hospital all the time, and that more key word charts be made available.

   The issue of responsibility for interpreters was also raised by respondents. Nurses suggested providing different communities with more information about the hospital to help them before they arrive. For example, for elective admissions, send advance information to families in their language explaining how the hospital works, and what to expect. A few respondents wanted
the clients to be responsible for bringing their own interpreters from the community.

Resources Used to Enhance Cultural Awareness

Literature has stated that nurse's knowledge of her client's culture was an important step in providing culturally sensitive care (Waxler-Morrison et.al., 1990). The questionnaire elicited nurse's knowledge sources related to ethnocultural groups with whom they worked. Respondent's use of available resources to provide them with an understanding of the client's culture and enable them to plan culturally appropriate care was also sought. The responses to the fixed-response and open-ended questions were examined in this section. The findings indicated the resources used by nurses to learn about their client's culture were varied. The urgency with which the information was needed again played a role in whether or not the nurses accessed what was available.

During the study period, a folder which provided a brief description of ethnocultural groups common in the catchment population of the hospital was available on each nursing unit. A brief comment on childrearing practices was also included. Each folder included a caveat cautioning the reader that the information should be used as a guideline only. Books related to
cultural groups were also available in the agency's Parent Resource Library. A number of nurses wrote that such information provided a useful starting point in providing culturally sensitive care.

Sources of Knowledge

Nurses were asked to identify the ethnocultural groups with whom they worked the most, and about whom they knew the most and the least. Many nurses identified the group with whom they worked the most as being the same group about whom they knew the least.

When asked where they acquired most of their information related to their client's culture, nurses identified a variety of sources. Twenty-six percent used books, 16% had experience with courses or seminars, 20% stated they had had inservices, but the largest group (34%) relied on other sources of information. Four percent did not identify any source.

The other sources of cultural information included work experience and exposure to patients from other cultures (60%), asking colleagues or other health professionals (25%) or from reading articles in the Family Resource Library (14%). Only ten percent of nurses had educational experiences related to cultural aspects of care. Most of these courses were related to describing the differences in health beliefs and
practices among ethnocultural groups.

These results indicated that very few nurses obtained their information from formal education sources. Most respondents relied upon informal sources of information such as colleagues and experience.

Available Resources

Fifty-five percent of respondents had a recognized resource person to assist in formulating care plans for clients from other cultures. All but one patient care area had a nurse educator, and 78% of the respondents identified a clinical resource person in their area. Three respondents described situations in which they had used a resource person to assist them in providing care. One of these respondents gave credit to her clinical nurse leader for enabling her to take time to access resources for a family.

Sixty percent of respondents knew of books available to help them understand the perspective of other cultures. Three participants reported they used these with success, and adjusted their care plan accordingly.

In their comments on the final page of the questionnaire, respondents requested education in the form of inservices and lectures related to various ethnocultural groups for whom they provided care. Some
respondents were very specific, requesting information related to a particular ethnocultural group, but most respondents wanted general guidelines pertaining to the cultural care of their clients.

Additional findings

The questionnaire asked respondents to describe resources and supports they felt would enable them to provide culturally sensitive care. Two groups of responses were identified. Overwhelmingly, nurses wanted information related to their client's culture. They also wanted greater access to and experience with interpreters.

Respondents cited knowledge and information related to their client's culture as a fundamental need. One nurse, afraid of cultural stereotyping warned against the use of 'quick' references for different cultural groups. Community involvement was also suggested by nurses who wanted community health nurses of certain cultures available as resource to staff.
Discussion

Communication is the central issue to be addressed when nurses are caring for children and their families in a culturally diverse paediatric setting. Paediatric nurses in this study did indeed experience difficulties when providing care to clients whose culture and language was different from their own. The respondents communicated a genuine desire to provide optimal care, but their success in managing care was described as being dependent upon the resources and supports available and how they were used.

Communication was central to the nurse's ability to provide care. This finding is consistent with the conceptual framework of the study, and is supported by Northouse and Northouse's (1985) Developmental Model of Health Communication. It has also been reported by Knafl, Cavallari and Dixon (1988) who found that family-centred care involves open communication and negotiation between professionals and families. Northouse and Northouse's model (Figure 4) illustrates the multidimensional and transactional nature of communication. According to Northouse and Northouse (1985), communication for the purposes of health care
is an ongoing process of transactions between health care professional and client.

Both health care professionals and clients (in this study, the child and family), bring to the transaction values, beliefs and perceptions based on their social context (Northouse & Northouse, 1985). This is congruent with Kleinman's (1978) conceptualization in which health care transactions occur between the explanatory models of professional and client which are based on different forms of social reality. The findings of the current study illustrate what occurred during transactions between culturally and linguistically diverse clients and professionals in a paediatric setting.

The findings of this study suggest an adaptation to Northouse and Northouse's (1985) model to illustrate the process of communication within a paediatric setting. Since the nurses' communication encompassed both child and family combining Northouse and Northouse's conceptualizations of the 'client' and 'significant others' would be more appropriate.
Northouse and Northouse (1985)

Health Communication Model

FIGURE 4
The categories of assessment and providing care described by respondents illustrated processes which occurred within the client-practitioner transactions and which were dependent upon communication. The ability or inability to complete these processes gave rise to subsequent consequences for respondents.

Assessment

Assessment of clients provides the foundation for all nursing care, a basis upon which all subsequent nursing diagnoses and treatment plans are formed. Respondents identified that more urgent situations such as admissions and emergency visits presented more of a challenge to client assessment.

Nurses needed to communicate to assess client histories, the family's response to new information or events, and cultural meanings. The family's response to a new situation, and cultural meanings of illness were particularly pertinent to the respondents in a paediatric setting. Assessing the family's response to a new situation or new information was a vital precursor to providing support and reassurance for respondents. Brown and Ritchie (1989) indicated paediatric nurses felt a high level of responsibility towards parents, and saw caring for them as a valuable part of their role. Despite identifying this as an
important aspect of their role, respondents were frequently in positions of being unable to provide this care.

The client-practitioner negotiation model of care provides direction for nurses to elicit from client's their explanatory model of care (Anderson, 1987). An understanding of the client's perspective has been shown to improve the effectiveness of nursing care. Assessment of the client to gain an understanding of his or her perspective may not occur due to the language barrier experienced by the respondents. Ineffective communication interfered with the nurse's ability to assess the client and to negotiate a mutually agreed upon plan for care.

The assessment of parenting behaviours provided an example particularly pertinent to the respondents in this study. Family structure and roles are shaped by culture and social context, and each family may demonstrate different parenting roles and behaviours. Brown and Ritchie (1989) found that paediatric nurses assessed parenting behaviours and modes of care as part of a complete assessment to ensure families' abilities to care safely for their children. Nurses in the current study reported difficulties in assigning meaning to the behaviours assessed, and some
recognized their definition of family and parenting as ethnocentric. Respondents were unable to elicit from parents an explanation of the behaviours. They were therefore unable to fulfill their roles as paediatric nurses.

The investigator speculates that education related to cultural perspectives would provide nurses with a reference point from which to begin assessing cultural meanings and parenting behaviours of their clients. However, education alone would not be sufficient. Without an individualized assessment of the client, knowledge related to the client's culture could lead to stereotyping. Nurses need also to recognize that the normative definitions of behaviour are culturally constructed and learn to negotiate common understandings with clients.

When respondents were unable to understand the clients' behaviour, or elicit an explanation for the behaviour, they formed judgements about the client. Non-compliance was recently defined by Thorne (1990) as "a conscious and reasoned decision not to adhere to professional's advice" (p.63). Dracup and Meleis (1982) identified two groups of non-compliant behaviours; acts of commission and acts of omission. Respondents in this study identified perceptions of
both behaviours.

These findings reinforce those of Anderson (1987) who found that non-compliance often resulted when health care professionals were unaware of the complexities of the client's situation. Clients and nurses operated from a different set of priorities. Knafl, Cavallari and Dixon (1988) found that nurses reported conflict when parents did not meet their expectations or exhibited behaviours they did not understand. Nurses in those situations made value judgements about parents and labelled them.

Compliance implies choosing behaviours which coincide with a clinical goal which is negotiated and mutually agreed upon. Respondents who were unable to communicate with their clients, were unlikely to have arrived at a mutually agreed upon goal for care. In some cases, education about the client's culture contributed to resolution of the perception. The example of the nurse who resolved her perception of non-compliance by educating herself about the client's culture illustrated that education of nurses may hold the key for interrupting the cycle. The same situation also illustrated that the respondent had not previously negotiated a mutually agreed upon plan for care. Labelling behaviour as non-compliant has
negative implications in that it locates the problem with the client rather than examining the system of care delivery that contributes to the perception.

**Processes of Providing Care**

As respondents proceeded to provide care to their clients, they encountered further difficulties. In some instances, respondents proceeded with care which was based on incomplete and inaccurate assessments. Other respondents described providing care to clients with whom they could not communicate. Both courses of action lead to what respondents described as suboptimal care of the client.

The role of the nurse in paediatric care has been identified as including providing information, teaching, and providing support to the families of clients (Brown & Ritchie, 1989; Knafl, Cavallari & Dixon, 1988). Respondents in this study indicated that in the presence of a communication barrier, they were unable to fulfill these aspects of their role as paediatric nurses to their satisfaction.

Knafl, Cavallari and Dixon (1988) found that nurses were often unable to fulfill their teaching role, and teaching most often occurred on an informal basis. The provision of informal teaching by respondents in the current study was virtually non-
existent due to the communication barrier. The only teaching that occurred was through arranged interpreters, which took time to organize.

Providing support and reassurance to client's families was a recurrent theme identified by the respondents and is consistent with the hospital's philosophy of care. In some instances, the respondents had been unable to assess the family's response to certain events. For other respondents, the situation implied the need for family support, but the language barrier prevented intervention. These findings are supported by Murphy and Clarke's (1993) study in which nurses reported difficulty supporting clients as a major theme. Knafl, Cavallari and Dixon (1988) argued that open communication, the foundation of the parent-nurse relationship, was invaluable in establishing and maintaining a supportive relationship.

Rodney's (1987) study of ethical responses in nurses indicated most respondents found it difficult to support family members from a different culture. Specific reasons for this were not identified. The results of the current study would suggest the difficulty was related to the nurses' inability to assess the client's need for support and the inability to communicate effectively to provide this support.
There is a paradox here in that respondents identified providing support and reassurance to parents as a major concern, yet no respondents described using an interpreter for this purpose. Interpreters were used for identified procedures and events rather than for ongoing support. How is it that respondents who had a genuine desire to provide optimal care were placed in the position of being unable to do so? The discussion of resources will address this question further.

Consequences for Nurses

When nurses were prevented from providing optimal care either at the point of assessment or during the process of teaching or supporting their clients, they incurred personal difficulties such as frustration and moral and ethical dilemmas.

Frustration

The theme of frustration experienced by respondents in this study reinforced the work of McCabe (1960) and Murphy and Clarke (1993). Both of these studies reported themes of frustration associated with caring for culturally diverse clients. Knafl, Cavallari and Dixon (1988) also reported that paediatric nurses experienced frustration associated with communication difficulties with parents. The
findings of the current study indicate that the experience of frustration begins with an inability to assess the client, and is magnified by the context of the situation. When nurses in British Columbia have the potential to be caring for a large percentage of non-English speaking clients, we can only speculate how often they feel frustrated.

Moral and Ethical Dilemmas

What was more significant was the emergence of a strong theme of moral and ethical dilemmas not previously documented by Murphy and Clarke (1993). Moral dilemmas arose for the participants in response to three situational contexts: threats to the safety of the child, obtaining informed consent, and the inability to provide optimal care.

Jameton (1984) has said morality is a set of values or principles to which one is personally committed. Nurses are further guided by a formal set of rules, the Canadian Nurse's Association Code of Ethics. Respondents experienced moral conflict when they were placed in situations in which they were unable to fulfill their role or do what they thought should have been done. For example, respondents expressed a commitment to family-centred care. They were prevented from fulfilling this commitment due to
the language barrier.

Wilkinson (1988) further identified moral principles which include harm befalling the patient, and failure to benefit the client. Respondents described situations in which their inability to communicate effectively lead to threats to the safety of the child. Respondents also reported that being unable to completely assess clients, or support families was distressing. It can be argued that these respondents experienced situations in which their moral principles were violated.

Obtaining informed consents in the face of a language barrier raised special concerns for respondents. Whether or not the respondents were aware of the language problem at the time of consent raises the issue of their professional responsibility.

These findings are of particular importance to nursing administration. In presenting the results of a study on ethical perspectives, Rodney (1987) stated that there is an implicit relationship between ethical dilemmas, moral distress and nurse burnout and attrition. Increasing cultural diversity of agencies will heighten nurses's stress and burnout unless supports are in place quickly. The legal implications of poorly informed consent must prompt agencies to act
quickly to ensure that effective communication occurs.

**Influencing Factors**

Nurses were often able to overcome the challenges presented by a language barrier and optimize care. Significant characteristics or contributing factors were identified. These were the nurse's personal philosophy, and the use of agency resources such as interpreters and other resources. These three sections will now be discussed under headings of philosophy, communication resources, and staff development.

**Personal Philosophy**

Respondents demonstrated that personal resources were instrumental in overcoming the difficulties presented by a communication barrier. Successful respondents identified a personal philosophy which valued differences among their clients. This philosophy enabled them to challenge the agency policies and to work with the differences.

Education is needed to make culturally sensitive care a standard for practice. The investigator speculates that providing nurses with education related to the importance of culturally sensitive care, and the knowledge and skills needed to implement this care might encourage nurses to adopt culturally sensitive philosophies.
Communication Resources

The use of interpreters was seen to enhance the nurse's ability to provide care but two factors hindered the respondents' success in using interpreter services, awareness and appropriateness of services.

The majority of respondents were unaware of the availability of formal interpreter services. They also thought them to be not readily accessible and expensive. They were also inexperienced in their use. As a result, they relied on family members and co-workers. The data provide examples of costs incurred as a result of not accessing interpreter services; one child had to stay an extra day for teaching, one mother had to stay extra time for rooming in, and other parents and nurses had to wait hours for an interpreter to arrive. The need for interpreter services seemed to be recognized at the last-minute in several cases. These delays and costs could have been avoided by planning ahead for an interpreter to be available for teaching. There was often an extended period of time for nurses to organize planned teaching sessions with the family. These situations reinforce the results of Rader's (1988) study which found that time was wasted by not having interpreters available and used appropriately. Despite the development of
formal interpreter services, these services remain underused. Increasing the nurses' awareness of and comfort with the existing interpreter system may enhance its use.

In some instances the client's right to confidentiality was breached because the interpreter used was inappropriate. Nursing has a unique body of knowledge and a unique function within the health care field (Leininger, 1978). When housekeeping staff, physicians or respiratory staff are used as interpreters, they are taken away from their own jobs in order to spend time with the nurse and family. Other health care workers are also not skilled in the practice of nursing. Housekeeping staff lack the medical expertise to explain medical problems and procedures in detail, and may not appreciate the issue of confidentiality. Physicians often lack an awareness of the importance of the psychosocial aspect of the nurse's role, interpreting only the medical facts of the child's condition, and not staying to help the nurse provide emotional support. The findings which indicated that respondents continued to access other employees as interpreters underscores the need for trained interpreters who understand the role of each professional, and the environment of the hospital.
Since assessment was described as a vital aspect of care particularly in the Emergency unit, having interpreters available there would be beneficial. A study similar to Rader's (1988) could help in further defining the need for an on-site interpreter. The ideal interpreter service would involve full-time trained interpreters available in the agency to assist with both identified teaching and assessment needs, and to help support parents in an ongoing manner.

Respondents described a paradox of valuing providing support to parents on an ongoing basis, yet not accessing interpreters to provide this care. The investigator speculates that respondents may not have recognized that supportive care could be a valid reason for accessing interpreter services. One respondent did suggest having interpreters available in the agency all the time to help nurses provide this support. There is a need to increase awareness of both interpreter services and resources available among nurses.

Written resources such as teaching aids and pamphlets were not widely utilized by the respondents. These resources must be used in conjunction with interpreters to assist with the mutual exchange of information between clients and nurses. The study
findings suggest the scope of existing resources in other languages needs to be broadened, and nurses need to be made more aware of them.

The study findings indicated that family members are providing most of the interpretation. Murphy and Clarke (1993) also observed that family members were the main interpreters, however, findings of the current study further illustrated that in the absence of family members, the responsibility fell to the professional to organize interpretation.

This brings to light the issue of ownership of responsibility for communication resources. Most respondents felt the nurses should be responsible for ensuring effective communication. This was supported by the Likert scale responses. Respondents indicated they wanted to be adequately prepared for this role, asking for greater interpreter services and more information about using interpreters. Some respondents, however, felt the community should be responsible for communication resources, asking for greater community preparedness, and wanting families to be responsible for interpreter services. One respondent wanted clients to learn to speak English before accessing health care in Canada. If the agency is to assume responsibility for communication
resources, changes to the current system need to be implemented. If the community is to be responsible, then the community must be informed as to their responsibilities. It is the opinion of the investigator that health care agencies should assume this responsibility, as communication is as vital a part of nursing care as physical care.

**Staff Development**

Very few of the nurses had received special education related to cultural issues, but most of the nurses indicated they wanted more education related to the cultural beliefs of their clients. Although all the nurses had access to the same resources, and only 10% had any special education related to cultural aspects of care, some nurses sought out resources for their clients, and used them successfully. This seemed to be related to the nurse's personal philosophy. Respondents whose philosophy valued cultural care of clients sought information and resources to educate themselves and provide optimal care.

Most nurses relied on informal sources of information such as colleagues and experience to gain knowledge about their client's culture. Northouse and Northouse (1985) state that informal communication channels supplement formal ones, but the pitfall is
that the information may not be complete or may be erroneous.

Respondents indicated almost unanimously that they wanted more information related to their clients' cultures. Some wanted specific cultural information, but most wanted general principles and guidelines to follow. These findings suggest that there is a need for educational intervention to foster culturally sensitive care. Education, however, must include both cultural knowledge and communication skills. Successful situations were those in which nurses were skilled in negotiating the basis of care with clients. Recognition by nurses of the reciprocal relationship of care delivery and the role of communication in the process is essential.

**Broader Issues in Health Care Delivery**

Encompassing and influencing the nurse-client transaction and the nurse's ability to provide care is the context of practice. If nurses were able to appraise their client and determine their needs, to what extent did the agency facilitate their ability to plan and carry out nursing care? The agency determines the resources available since it controls the funding for providing education, resources and interpretation services (Malone, 1988).
The context of care did not emerge as a theme from the responses, but in considering the whole picture, it became clear that the agency as the context of practice was a major influence on the nurse's ability to plan and carry out care.

The institution's philosophy plays a role in the nurse's success in managing care (Malone, 1993). The mission statement of BCCH (1993) demonstrated a philosophical commitment to the cultural considerations of care. The ethnocultural survey completed, and initiation of interpreter services indicated a commitment to culturally sensitive care. As the findings of this study indicate, however, the current system needs some improvement, and further commitment in more tangible forms is needed.

The context of care did encourage family-centred care, but it remained up to the nurse to interpret the meaning of family. This finding is congruent with Knafl, Cavallari and Dixon (1988) who found that the definition of family-centred care was usually a reflection of the professional's views. This underscores the need for nurses to negotiate with the family to determine roles and expectations for care. Nurses continued to struggle with dilemmas because they were placed in situations in which they were
unable to provide what they perceived to be optimal family-centred care they valued.

None of the nurses described situations in which the agency impeded their ability to provide care. There were however, several examples in which nurses chose to interpret the agency policies a certain way so as to facilitate care of their clients.

One nurse described a situation in which parents wanted their large extended family to learn to care for their special needs child. The unit had strict visiting policies, and the extended family members had repeatedly been refused entry. Upon discovering this, the respondent chose to challenge the visiting policies and include all family members in visiting privileges. In this situation, negotiation with the family enabled the nurse to provide optimal family-centred care based on the family's perception of what constituted their 'family'.

In the larger health care context, it is imperative for health care agencies to respond quickly to ensure the delivery of culturally sensitive care. The proportion of foreign-born B.C. residents is predicted to increase over the next decade. The mandate of the Closer to Home document states that the responsibility for health care management is to move
out of the hospitals and into communities (B.C. Royal Commission on Health Care and Costs, 1991). The aim is for shorter hospital stays, and increased community involvement. The findings of this study indicate that, for culturally diverse clients, the absence of effective communication results in longer hospital stays and less than optimal care. As communities assume more responsibility for health care management, it is vital that they be adequately prepared to do so. In the sphere of paediatric care, parents must be well-equipped to care for their children in the communities. It is urgent that nurses be prepared with the knowledge and skills necessary to engage in negotiation with their clients to foster optimal care. Communication must be effective to enable nurses to provide the support, information and teaching parents need so they can assume the care of their child upon discharge from hospital.

Summary

The findings of this study indicate that nurses have a strong desire to provide optimal care to their clients, but are hampered by the resources and interpreter services available. The findings indicate that the nurse's personal philosophy plays a large part in her success in managing care. Nurses with a
philosophy which values client differences manage care by choosing to access resources which enable them to work with the differences among clients.

The findings of the study indicate that nurses need to be made aware of the availability and appropriateness of resources which exist. The current system of interpreters is not being used to its full potential. Some changes such as greater diversity of written resources and greater availability of interpreters have been suggested.

The findings show that nurses who are unable to provide optimal care to clients experience moral and ethical dilemmas and frustration.
CHAPTER FIVE

SUMMARY, CONCLUSIONS AND IMPLICATIONS

This chapter will present a summary of the research study followed by conclusions based on the findings of the study. Implications for nursing practice, education and research will then be presented.

**Summary**

In British Columbia, the health care institutions are becoming increasingly culturally diverse as the client population changes. Although there is extensive literature outlining what information is required by nurses in order to provide culturally sensitive care, little is known about the main issues nurses face in trying to provide culturally sensitive care. The purpose of this study was to identify and describe the main issues for nurses who cared for culturally diverse clients and families in a paediatric inpatient setting. The second focus of this study was to describe the resources and supports nurses utilized and needed in order to provide this care.

A review of the literature identified the major theoretical perspectives which provided direction for the delivery of culturally sensitive care. Kleinman's (1978) cultural systems model was used as a
conceptualization for this study. He described three domains in which health is experienced and reacted to; the professional, popular and folk domains. Kleinman's (1978) conceptualization provided direction for examining the effects of conflicting explanatory models of health and illness from the professional's perspective.

Several researchers reported that nurses experienced difficulties caring for clients from different cultures (McCabe, 1960; Murphy & Clarke, 1993). Knowledge and skills necessary for the provision of culturally sensitive care have also been identified (Anderson, 1987; Lynam, 1992; Waxler-Morrison et al., 1991). The role of the agency has also been identified as being importance in fostering culturally sensitive care (Harris & Tuck, 1992; Malone, 1993). Despite this wealth of knowledge, nurses continue to experience difficulties providing culturally sensitive care.

A descriptive approach was used to address the following two research questions: 1) What issues do nurses identify as influencing their ability to provide culturally sensitive care in a paediatric setting? 2) What agency-based resources facilitate or hinder the nurses' ability to provide culturally
A questionnaire developed and pilot tested by Lynam, Sauro et al., (1991) was used following minor revisions. The questionnaire consisted of fixed-response questions and Likert scale rankings, and two open-ended questions seeking the respondents' experiences caring for a child and family from a culture different from their own. The investigator used a convenience sampling approach to recruit 42 respondents from a paediatric inpatient setting. Descriptive statistics were used to summarize the fixed response questions and to describe the sample. The open-ended questions were subject to content analysis.

The findings indicated that the respondents had a genuine desire to give good care, but they were dependent upon the resources available. Communication was the overriding issue facing nurses who cared for clients from another culture. An inability to communicate affected the nurse's role in several ways. Both assessment of the client, and provision of care were reported to be affected by the communication barrier. When the respondents were unable to communicate with their clients for the purposes of assessment or to provide care, they experienced
frustration and moral dilemmas.

Difficulties were resolved when the nurse's personal philosophy valued client differences, and enabled her to negotiate alterations in the care plan to suit the client's needs. Interpreter services and available resources were also factors which affected the nurse's ability to participate in the provision of effective care.

The nurses relied heavily on family members for interpretation, and were unaware of the nature of the formal interpreter services available and how to work with them. Responsibility for the provision of interpretation was assumed by the clients' families, and in their absence, the nurse.

Respondents also indicated they needed more information related to their clients' cultures. They were unaware of what was available to them to increase their knowledge, but identified that they needed inservices or courses to assist them in managing care.

Conclusions

The following conclusions were drawn from the study.

1) Communication is the central issue faced by nurses in providing care to culturally diverse paediatric clients and their families.
2) Difficulties with communication provide a challenge for nurses to assess their clients.
3) Difficulties with communication make it challenging for nurses to provide supportive care such as teaching and providing information to families. In some instances this can result in threats to the safety of the child or prolonged hospital stays.
4) The inability to communicate with clients results in nurses feeling frustrated and leads many to experience moral and ethical dilemmas.
5) Difficulties are overcome when the nurse's philosophy values client differences, and they are enabled through interpreter services and other resources to negotiate an understanding of common goals in care with clients.
6) Respondents want more information related to their client's culture and need to know how to incorporate such knowledge into processes of care delivery.

Implications

Practice

While this study began with the premise that culturally sensitive care is responsive to client's needs and sought to understand issues from the perspective of the nurses, cultural difference was interpreted largely in terms of language differences.
When nurses were able to speak the same language and elicit the client's perspective on care and proceed to negotiate, the cultural difference was not problematic. When, however, nurses and patients did not speak the same language, the process of care delivery was impeded. We must first separate language and culture, and consider the issue separately.

The results of this study have implications for nursing practice from registering bodies to practice agencies. The definition of culturally sensitive care must be used to develop a standard for practice to ensure an equal standard of care for all clients.

Health care agencies must recognize the need to put in place supports to ensure the provision of culturally sensitive care. The adoption of a philosophy which reflects the valuing of culturally sensitive care would be an essential step. This philosophy must be consistent throughout the mission statement, strategic plan and budget. Sufficient budgetary resources must be allocated to ensure appropriate programs are established and maintained. Funding must be allocated to provide sufficient education and resources for nurses. Further development of written resources must proceed quickly. An assessment of each nursing units' needs for
teaching and supportive resources would be valuable. Nurse managers have a role in supporting staff nurses' efforts to ensure culturally appropriate care. Staff role performance appraisals should include a cultural component to ensure ongoing commitment to culturally sensitive care.

Paediatric agencies should not consider culturally sensitive care to be just a nursing mandate, but should include other professions such as social workers, dieticians and physicians in education. Community agencies should also be included to foster a team approach to optimal care.

The study raised questions about responsibility for ensuring effective communication. If the responsibility is to fall on the agency, then steps need to be taken quickly to ensure interpreters are available and that all staff know how to access them and work with them. If agencies choose to defer to the community, then similar actions need to be taken to enlist the support of the community.

The issue of the employer's responsibility for the well-being of employees must also be addressed. Cultural diversity is increasing in hospital populations, and nurses will continue to face frustration and ethical dilemmas on a daily basis
unless resources and supports are in place. Nurses must be provided with a forum for voicing their concerns, and discussing the challenges they encounter. Prompt resolution of the communication difficulties would be beneficial in reducing the frustration and ethical dilemmas experienced by nurses, and ensuring job satisfaction.

Education

The findings of this study suggest nurses wanted more information related to their clients' cultures. Nurses indicated they valued culturally sensitive care, but needed more information to enhance their ability to provide this care. Undergraduate and continuing education programs must incorporate cultural issues and skills into curricula. It is beyond the scope of this paper to address the various methods for incorporating cultural concepts into curricula, but several approaches have been documented (Leininger, 1988; Lynam, 1992).

Educational programs in paediatric centres should educate nurses about cultural issues and provide them with the skills they need to incorporate this information into the process of care delivery. It is essential that nurses develop a sound understanding of the process of culturally sensitive care delivery.
Increasing the nurses' awareness of the availability and appropriateness of interpreters would improve communication between clients and nurses. Providing nurses with opportunities to practice working with trained interpreters would encourage their use. The investigator suggests a model such as the client-practitioner negotiation model be taught to enable nurses to negotiate mutually agreeable goals for care with clients.

Nurses also need opportunities to learn the necessary knowledge and skills to effectively resolve ethical dilemmas they encounter in their practice. Educational sessions should reflect this reality of practice.

Research

The findings of this study were localized to a paediatric setting. Exploring the issues for nurses in different settings such as community agencies could provide further insight into ways of enabling optimal care to clients from different cultures.

Communication was shown to be the overriding issue for nurses, affecting their ability to provide care. Studies which examine more effective or inexpensive means of ensuring communication may enhance the nurse's ability to provide care. A study
which compares the cost of interpreters to the cost of providing health care in the face of a communication barrier could provide further validation for the use of interpreters in a paediatric setting.

Studies which elicit the issues faced by clients in a paediatric setting could further assist nurses in providing care. Similar studies have been done in adult settings but, as the findings from this study indicate, paediatric settings have unique properties. As some respondents indicated, families also experienced frustration associated with a language barrier. How do families cope with these experiences?

Opportunities exist for nurses in each area of the agency to improve client communication. A needs assessment defining specific aspects of care which would benefit from further development of written material to enhance communication could be conducted by the nurses themselves.

There is a need to examine the moral and ethical dilemmas nurses experienced in an effort to understand how nurses coped with these difficulties.

This descriptive study was useful in gaining knowledge related to the provision of care in a paediatric setting. It is important that other research studies be undertaken to further illuminate
ways of providing optimal care to all clients.
References


APPENDICES
Appendix A

Nursing in a Multicultural Society:
Issues and Nursing Responses NMS-INR
Please answer by circling the answer which applies or by filling in the blanks where appropriate.

1) What age group are you in?  
   20-25  26-35  36-45  46-55  >60

2) Gender:  Male  Female

3) What is your highest education level?  
   _Diploma  _BSN  _MSN  _PhD  _other

4) How many years have you been working as a Nurse?  
   0-6mos  7mos-1yr  1-5yrs  5-10yrs  >10yrs

5) How many years has it been since you graduated from your basic nursing program?  
   0-6mos  7mos-1yr  1-5yrs  5-10yrs  >10yrs

6) What is your employment status in an acute care setting now?  
   full-time  part-time  casual

7) Approximately how many hours do you work in a two week period?  
   <24 hours  25-36hrs  37-60hrs  >60hrs

8) Are you fluent in any language other than English?  
   yes  no
   If yes, please specify________________________
9) Do you write or read any language other than English?
   yes     no

   If yes, please specify________________________

10) Is your agency a 1) tertiary   2)secondary
    3) community centre?

11) Approximately how many beds are open in your agency?
    <200    201-250    251-350    351-500

12) Is your emergency department available to the public 24 hours a day?
    yes     no

13) Is your agency a teaching hospital?
    yes     no

14) How many nurses are on staff per shift in your unit?
    1-4      5-10     11-15     16-20

15) In what area of the hospital do you work?
    modules
    ___ambulatory care
    ___Emergency
    ___SCN

16) Do you have a nurse educator available to your unit?
    yes     no

17) Do you have a clinical resource nurse or someone in an equivalent role (i.e. Assistant Head Nurse) available to your unit?
    yes     no
18) The ethnocultural groups I work with the most are: ________________

19) The ethnocultural community groups about which I feel the most knowledgeable are: ________________

The ethnocultural community groups about which I feel the least knowledgeable are: ________________

20) My knowledge sources have included:

____books
____courses
____inservices
____other____________________

Please answer the following questions to the best of your knowledge.

21) Language barriers can be reduced through the use of interpreters. Are you aware of any formal interpreter service in your hospital?

yes  no

22) When is interpreter service available in your hospital?

1) 24 hours a day
2) during office hours (8-4 or 9-5)
3) depends on availability
4) I don't know
5) Not applicable

23) How do you access the interpreter?
Please use the scale provided and circle the response which best reflects your feelings.

24) To what extent are the following interpreters used by you in your practice?

   a) trained interpreters with knowledge of medical terminology
       1  2  3  4  5
       never always

   b) trained interpreters with the ability to provide cultural interpretation
       1  2  3  4  5
       never always

   c) volunteer interpreters
       1  2  3  4  5
       never always

   d) client's family members
       1  2  3  4  5
       never always

   e) other nursing staff
       1  2  3  4  5
       never always

25) If interpreter services are used, are they normally organized by:

   staff 1  2  3  4  5
          never always

   family 1  2  3  4  5
          never always
26) Information can be provided for client teaching through the use of translated materials. Does your hospital have written materials for teaching non-English speaking clients?

yes    no

27) Do you know if any of the following resources for client and family teaching are available in languages other than English and French in your hospital? (Please check all that apply)

--pamphlets   --videos
--posters     --slides or films
--flip charts  --tape cassettes
--books       --other (describe)__________
--maps

28) How often do you find yourself using these resources in your nursing practice?

1  2  3  4  5
Never  5 Always

29) If you have these resources available and choose not to use them, is there a particular reason for this?

30) A list of key phrases in both English and in the language of the client can be posted by the client's bed to assist in nurse-client interaction. Have you seen this tried in your hospital?

yes    no
31) Literature suggests that health care institutions provide inservice education to teach health care professionals interviewing skills required to elicit relevant cultural information from their clients. Have you had such an educational experience? If yes, where, and do you find it helpful?

yes no

Where? ____________________________
Helpful? _________________________
Why or why not? ____________________________

32) Do you have resource people you can turn to when constructing a care plan for a client whose cultural background is different from your own?

yes no

33) Do you have textbooks on the unit or in the hospital to help you understand the health care beliefs and practices of clients whose cultural background is different from your own?

yes no
34) Health care literature suggests that health care professionals experience problems/difficulties when working with clients of different ethnocultural communities.

a) Could you identify a recent experience where you had difficulty caring for a child and family, and this difficulty was related to cultural differences? Describe the incident.

b) Describe how you dealt with the situation, and what resources and supports you drew upon. You may use the back of the page if necessary.
35) Could you describe a situation in which you were able to overcome the obstacles to provide optimal care for a child and his or her family whose culture differs from your own.

a) Describe the situation

b) What contributed to your success in this instance?

c) Please identify any resources you found helpful in managing the situation.
36) Describe resources or supports you would like to have to enable you to care more effectively for a child from a culture different from your own.


37) Please add any further comments you may have related to the care of children and their families from culturally diverse backgrounds.

End of questionnaire

Please seal this questionnaire in the envelope provided and leave it in the box on your unit.

Thank you for your participation
Appendix B Letter to Head Nurses

Dear ________________

My name is Mary Spencer. I am a graduate student in the Master of Science in Nursing program at the University of British Columbia School of Nursing. I am conducting a nursing research study entitled Nurses' Perspectives on Caring for Clients in a Culturally Diverse Paediatric Setting.

The purpose of this study is to describe the issues nurses report when caring for culturally diverse children and their families in B.C. Children's Hospital. Resources and supports nurses use to provide culturally sensitive care will also be explored. I would appreciate your assistance in recruiting participants for this study. I am seeking nurses who have worked at least one year on your unit, are fluent in English, and have cared for children and their families from a culture different from their own.

Nurses will be asked to complete a questionnaire which will take approximately 30-45 minutes. Participants will be informed that they are not obliged in any way to participate in this study, however, completion of the questionnaire will imply consent to participate. Their identity will be kept strictly confidential.

I would like to meet with the staff of your unit to discuss my study and recruit participants. I will contact you in the next few days to arrange a convenient time and place for this meeting. I will then provide interested staff with a questionnaire and answer any questions they may have about the study.

Please feel free to contact me, or my faculty advisor if you have any questions.

I thank you very much for your cooperation, Sincerely,

Mary Spencer, RN, BN.
MSN Student, UBC Phone: xxx-xxxx

J. Lynam RN, MSN Phone: xxx-xxxx
Thesis Chair
Associate Professor
UBC School of Nursing
Appendix C: Letter to Potential Participants

Research study: Nurses' Perspectives on Caring for Clients in a Culturally Diverse Paediatric Setting

Dear Colleague,

My name is Mary Spencer. I am a nurse in the Master of Science in Nursing program at the University of British Columbia. I am conducting a study to explore what it is like for nurses to care for a child and family who are from a culture different from their own.

A review of the literature indicates that the patient population is becoming increasingly multicultural, and that this does have an affect on nursing practice. The descriptions of your nursing experiences and the resources and supports you use when caring for families from different cultures will be very helpful in developing a better understanding of this process.

If you choose to participate in this study, you will be asked to complete a questionnaire related to caring for a child and family who are from a different culture. This will take 30-45 minutes. Completing the questionnaire will imply your consent to participate in this study. You will not be identified in any way. Only the investigator and thesis committee members will have access to the responses.

Please understand that you are under no obligation to participate in this research study and that your refusal will in no way affect your employment status.

I will be coming to speak to you to explain the study further. In the meantime, please call me if you wish to participate in this study, or if you wish further information about the study.

Thank you,

Mary Spencer, RN, BN.
Phone: xxx-xxxx

Judy Lynam, RN, MSN
Thesis Chair, Associate Professor
UBC School of Nursing
Phone: xxx-xxxx
Appendix D: Participant Information Letter

Research Study: Nurses' Perspectives on Caring for Clients in a Culturally Diverse Paediatric Setting

Dear Participant,

Thank you for participating in this study. The purpose of this study is to obtain information on how paediatric nurses respond to the challenge of caring for a child and family who are from a cultural background different from his or her own.

Although participating in this study will not benefit you immediately, the findings of this study may have implications for both nursing education and practice.

Your participation in this study is voluntary, and you may withdraw at any time without jeopardizing your current position. Your completion of the questionnaire will imply your willingness to have your responses used for the purpose of the study. You will not be identified in any way.

Please find enclosed, a questionnaire which will take about 30-45 minutes to complete. Seal it in the envelope provided when you have finished, and place it in the box on your unit.

I thank you very much for your assistance,

Sincerely,

Mary Spencer, R.N., B.N.
Phone: xxx-xxxx