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Article type   : Original Article

Title Page

Title: Resigned indifference: An explanation of gaps in care for culturally and linguistically diverse patients'

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Aims: To develop a theory that explains students and registered nurses' behaviours when caring for culturally and linguistically diverse patients'.

Background: Despite ongoing calls for improvements to the quality of patient care, the continued reports of substandard care to patients from diverse cultural and linguistic backgrounds are concerning.

Methods: A classic grounded theory methodology incorporating focus groups (n-10) and individual interviews (n-30) with students and registered nurses in one region of Ireland.

Findings: Participants resolved their main concern of *uncertainty* through *disengagement (masking, distancing and fitting in),* which was sustained by *resigned indifference,* resulting

in gaps in care. *Resigned indifference* explains how participants were aware of the consequences of disengagement, but became resigned and accepting of substandard care.

Conclusion: This study explains how nurses want to provide quality care, but gaps in care to culturally and linguistically diverse patients' are perpetuated through *resigned indifference*.

Implications for Nursing Management: Nurse Managers need to understand nurses' behaviours as a means of supporting collective ways of addressing gaps in care for culturally and linguistically diverse patients. Strategic leadership in developing culturally responsive structures is essential. Nurturing nursing values such as; commitment, compassion, and courage through education and leadership is a priority.

Introduction:

Providing quality, safe and efficient healthcare are key priorities for healthcare services globally. However, delivering this vision is challenging as evident by the continued reports of widespread substandard patient care (Bagnasco et al., 2017; Blackman et al., 2018). 'Care erosion' (de Vries and Timmons, 2015), 'lapsed care' (de Vries and Timmons, 2017), 'unfinished care' (Jones et al., 2015), 'cutting corners' (Jones et al., 2016) and 'missed care' (Gibbon and Crane, 2018) are concepts used in the literature to describe some of the concerning realities facing nursing practice. However, it remains unclear how nurses prioritise care needs for culturally and linguistically diverse patients and what influences these priorities. Cultural and linguistic diversity is a term used to identify the range of different cultures and language groups represented in the patient population (U.S. Department of Health and Human Services, Office of Minority Health, 2014).

Like many countries, Ireland has experienced overwhelming transformation to the cultural and linguistic diversity of its population, highlighting a level of complexity of sociocultural diversification, which exceeded any previous migration trends. Migrants to Ireland are a diverse group in terms of their country of origin, culture and language spoken, with over 612,018 people in Ireland speaking a foreign language at home. Polish, French, Lithuanian and German are the top four non English languages spoken (Central Statistics Office, 2016). Consequently nurses have experienced challenges in caring for the 199 different nationalities that constitute the social make-up of the new unchartered multicultural Ireland (Markey et al., 2018). Although not unique to Ireland, the growing reports of cultural insensitivity is concerning (Hart and Mareno, 2016; Almutairi et al., 2017), but has received limited attention within the discourse on 'missed care'. The importance of building capability and capacity to provide culturally responsive care is now paramount. Culturally responsive care is the delivery of quality person-centred care in a way that respects cultural and linguistic preferences (Gill and Babacan, 2012). It is an important component of quality nursing care; however is often seen as separate as opposed to integral to nursing activities (Papadopoulos et al., 2016).

Background:

Adapting nursing practices to appropriately respond to a growing culturally and linguistically diverse patient population is complex (Kovner et al., 2018). Consequently, nurses experience a range of challenges, such as; communication difficulties (Taylor et al., 2013); feeling ill prepared (Halabi et al., 2018) and having prejudices and biases (Almutari et al., 2017). However, there is a paucity of research exploring how nurses deal with these challenges in their daily practice and the impact of their decision making on patient care. The evidence highlights how nurses recognise the importance of providing culturally responsive care (Halabi et al., 2018; Wang et al., 2018). However, little is known about the factors that influence their ability to apply this understanding in increasingly complex healthcare settings. Ogbolu and Scrandis (2018) draw attention to the key role that nurse leaders have in prioritising culturally responsive services. Similarly, Truong et al. (2014) and McCalman et al.

(2017) argue the need to scrutinise the culture of the organisation where care is delivered as a means of improving culturally responsive care, but until recently this has received little attention. This study aimed to generate a grounded theory explaining nurses' behaviours when caring for culturally and linguistically diverse patients', in Ireland. It was guided by the following research question; 'What are the challenges experienced when caring for patients from diverse cultural and linguistic backgrounds and how are they dealt with?' While XXXX, (2018) reports how 'uncertainty' is the main concern for participants in this study, this paper explains the patterns of behaviour used to deal with these uncertainties and the factors that influenced these behaviours.

Methods:

A classic grounded theory approach (Glaser, 1978), although no less rigorous than other approaches seemed the best fit for this study.

Sample and setting:

The sampling approach was sequential, incorporating purposive sampling initially, which was superseded by theoretical sampling, signifying data sources that would further contribute to theory development. Initially, all students registered on the BSc general nursing programme in years 1-4, in one Higher Education Institute in Ireland, were invited to participate. Student nurse focus group data revealed that nursing students were aware of the importance of culturally responsive care, but felt unable to apply this understanding in clinical practice; signposting the need to explore registered nurse (RN) perspectives. Therefore RNs working in the four general hospitals that cover the region were also invited to participate. This study was approved by the research ethics committee of the University and Hospitals Group (EHSREC09-05).

Data collection:

Focus groups superseded individual interviews, assisting with gathering wide ranging data, whilst exploring group opinions and interactions. Eight focus groups were facilitated with student nurses, exploring experiences at each level of their programme. Two focus groups were facilitated with RNs, ranging in ages, experiences and responsibilities. Each focus group had 6-9 participants, lasted between 72-98 minutes (table 1) and were recorded and transcribed verbatim. A moderator (KM) facilitated the discussions, whilst a co-moderator took conceptual notes and recorded group interactions. These notes helped with content data analysis, capturing nonverbal interaction data such as; facial expressions, gestures and tone, pitch and volume of interactions. Three broad questions guided the focus group discussions; 'tell me about your experiences of caring for culturally and linguistically diverse patients'?'; 'what challenges did you experience?'; 'how were those challenges dealt with?'

Individual interviews assisted with gaining a more in-depth exploration into issues that emerged during focus groups. Individual interviews with students (n-20) and RNs (n-10) lasted between 32–75 minutes (table 2). A separate interview guide using open ended questioning guided the conversations (table 3), but interviews became more focused as codes and categories began to emerge. Interviews were recorded and transcribed verbatim with permission from participants.

Data Analysis:

Data were analysed using the constant comparative framework of open, selective and theoretical coding (Glaser, 1992). During open coding, transcripts were read, identifying trends in data that answered the research question. In vivo coding where key statements within transcripts were highlighted and a code that captured the essence of the incident was assigned. The researcher (KM) carried out initial open coding informing team discussions ensuring codes and categories were verified and systematically generated from data. Once, uncertainty emerged as the main concern, data collection and analysis became more focused on exploring patterns of behaviour used to process uncertainties.

Trends in codes were grouped together to form categories and the development of a core category that integrated how participants processed their main concern. For example, one continuous pattern of behaviour that emerged across all data sources was how participants described *avoiding encounters, delaying care, staying away, focusing on tasks* and *passing responsibility*. These codes were grouped together as they all referred to the same pattern of behaviour of *avoidance* and *distancing*. Although a raft of *disengagement* strategies were overtly described and participants were aware of the negative implications of their actions or omissions, it was sustained by *resigned indifference*. Categories were developed and saturated, whilst de-limiting codes that had no relevance to *disengagement* or *indifference*. During theoretical coding, particular connections between codes and categories were examined, using coding frameworks informed by Glaser (1992). Memos were written along the way recording thoughts and relationships between data, helping with conceptualisation.

Findings:

This grounded theory explains how students and RNs used a raft of disengagement strategies, *masking, distancing* and *fitting in,* to deal with their uncertainties when caring for culturally and linguistically diverse patients. Disengagement resulted in gaps in care that went un-noticed, albeit due to thoughtlessness, ignorance and inability to question practices. *Resigned indifference* explains how nurses were sometimes aware of the implications of disengagement, but became accepting, resigned and indifferent to substandard care.

Masking

Masking explains the dissonance between how students and RNs think and how they acted with patients and peers. Participants described *masking personal beliefs* and *masking knowledge limitations.* Masking helped ease the personal discomfort with acknowledging stereotypes, but attitudes and practices went unchanged.

Both student and RN participants reported having stereotypes, prejudices or biases. However, instead of addressing such ethnocentricities, participants described *masking personal beliefs,* which explains how they learnt to put such views aside temporarily.

> *"I do think we do stereotype in our heads…we may not…..…act it out. I was thinking it in my head. Now …I didn't let it affect my care, I put my own views aside for a while whilst at work. We can do that so easily. I just put on my smile and although I might be thinking one thing I am doing something else to get through the day."* (2nd year student interview)

All participants consistently described *masking knowledge limitations* regarding different cultural norms and religious beliefs, due to feelings of unease with not knowing how to act.

"I would be very anxious because if you approach them in any way…like even though you wouldn't mean to offend them. You would have a real fear of doing something wrong". (3rd year student interview)

R*N*s consistently described feeling 'under pressure' to portray expert knowledge and as a result also disguised their knowledge limitations, as opposed to finding solutions when unsure.

'It's not that we don't want to do a good job but sometimes we are so afraid of ourselves that we feel the need to disguise parts of ourselves…and of course what we don't know.. We are under pressure to be seen as that 'good nurse' who is extra knowledgeable and competent and knows what they are at…not just by the patient but by our colleagues too….so you just do what you have to."
(RN focus group)

Distancing

Distancing explains how participants used *physical and psychological distancing* strategies, failing to appreciate the learning that occurs during cross-cultural encounters. *Psychological distancing* explains the limited attempts at developing therapeutic relationships. Not surprisingly, participants consistently described the difficulties experienced when communicating with patients from diverse linguistic backgrounds. However, some student participants suggested that language barriers are sometimes overused as an excuse for failing to meaningfully engage with patients. When language barriers were evident, it made disengagement less discomforting.

"*It was very hard to explain anything about any of even the basic nursing procedures. We spoke different languages and he didn't understand me…so that one to one just couldn't happen.* However this may be overused at times as an excuse for poor care"
(3rd year student focus group)

Although the majority of participants expressed feelings of guilt due to feeling unable to communicate effectively, there were minimal attempts to overcome language barriers, as exemplified by the following.

"You feel bad… you are left wondering is he lonely then, because you can't really communicate with him." (2nd year student focus group)

"It's not our faults, what do they [management] expect to happen if they don't provide us with the staff or interpreters to help us to communicate appropriately"
(RN interview)

Physical distancing explains how participants used different avoidance strategies. In some incidents this was described as avoiding patient contact.

"My worry of offending someone is taking over from my ability to care for them.. so often I avoid having contact with them as a precaution."
(4th year student interview)

In other contexts, both students and RNs described predominantly *focusing on physical aspects of care*, which was contextualised as *carrying out tasks.*

> *"There is a greater focus on physical care but because we have little in common that building of a rapport doesn't really happen and that is just it."*
>
> (2nd year student focus group)

Time is precious in busy and under resourced healthcare settings, but instead of considering ways of using time effectively, the focus was to 'do enough to get by'.

> *"I am sorry to say but if you know it's going to take so long you just avoid going in. If eventually you have to, then you go in, you focus on doing their physical care you know…the vital signs; wash them; make the bed and do enough to get by ……"* (RN interview)

Fitting in

A culture of care based on routine practices allowed disengagement to go unnoticed. Although having a routine helped provide structure to the working day and helped ease the discomfort with being unsure, it was problematic when nurses felt compelled to comply with routines that were rigid and ethnocentric.

> *"I am working …in…a bit of an old-fashioned ward where you stick to the routine. That's the culture of the ward…the care that is provided is based on a routine of certain practices…certain things need to be done by a certain time."*
>
> (RN interview)

Both student and RN participants described how evaluation of standards of care was often based on observable features such as how the patient looked. This enabled nurses to prioritise physical care at the determent of providing holistic care.

> *"That's a routine …..a tick box system and it's straight forward because you just follow that and do all those tasks required at the given time...and then you have no worries. We felt we had done an absolutely fantastic job as that is the routine and now people can see we were good."   "*
>
> (RN interview)

Resigned Indifference:

Resigned indifference explains how participants were sometimes aware of the negative implications of disengagement, but became resigned and accepting of substandard care. In this way, culturally insensitive behaviours were maintained and gaps in care sustained. Although participants consistently articulated that substandard care was not intended, there was a general failure to take action to improve the care described.

> *"It can be compromised sometimes, but not intentionally.. we just do not know what to do or at times we just don't have the time. You know we are just under so much stress, that you can only do what you can do."* (4th year student interview)

A view mirrored by RN participants.

> *"I just ignored him…..I just didn't tell anybody and I just….tried to communicate the least amount with the guy, just did the bare minimum for the person…"*
> (RN interview)

Although, not disputing the pressures nurses were feeling in an increasingly demanding role, taking measures to disguise substandard care appeared to take precedence over trying to improve it.

> *"But then you will come onto the wards and like…I know even I don't do it anymore…I…because you are too busy or it's just…you run out of steam…you just don't bother….."* *(RN* interview)

Complacency was also described, where both students and RNs failed to question their own practices and didn't see anything wrong with care provided or chose to ignore the implications of actions or omissions.

> *"You know they did the same with every woman, explained everything the same. It didn't matter whether the women understood or not, but they were told and that was it, you know. They were trying the best they could but regardless it was obvious the care provided wasn't right. However nobody did anything about it…"* (1st year student interview)

The collective nature of how gaps in care went unchallenged highlights the lack of commitment and courage to question practices. Devolving personal responsibility for influencing changes to practice was a recurrent finding across all participant groups.

> *"But maybe I am the type of person that unless I have to do something I won't do it. If I feel that it's not a priority then single-handedly why would I be breaking my neck trying to change the world when it's not seen to be an issue for…I suppose for others."* (RN interview)

During the course of discussions, participants recognised that behaviours described were not congruent with their responsibilities. However, there was an ease with blaming others and absolving themselves from personal responsibility for gaps in care. Some RN participants described a weariness associated with constantly trying to do the right thing, when resources were minimal. However, as a consequence of working with colleagues where there were no repercussions for any level of substandard care, taking shortcuts was easier.

> *"it's just sometimes well its hard….cos you… get tired of trying so hard …when your other colleagues might not be doing so and nobody says anything to them….so what's the point…"* *(*RN interview)

Student participants described how it was easier to collude with insensitive behaviours as opposed to challenging them.

> "We change our behaviours…so I know what I should be doing but because …. I need to adapt with what goes on in the ward and I need to get along with colleagues… So it's not an individual thing, it's tackling an organisation."

(3rd year student interview)

Similarly, the majority of RN participants described knowing what to do, whilst turning a blind eye to what was happening around them. Although acknowledging the discomfort associated with challenging poor practice in any context, accepting sometimes less than perfect care was often seen as the easier option.

> *"We know the right thing to do. But when we go into practice we don't do it. Or we see somebody not doing it…and we….just don't feel able to challenge it. Yes we want to fit in which is maybe why we don't challenge but the rest I am not sure about it's like we close our eyes. ……. we just become accepting of it.*
> (RN focus group)

Instead of exploring ways to improve care, participants became resigned to and accepting of the standard of care provided. The following interview extracts summarise how the majority of participants acknowledged that they could have done more to improve standards of care, but didn't.

> "*The problem is that we are just so busy and under pressure to get everything done…but I just felt that that extra little bit of time to explain could have been taken and I know it wasn't their fault. I mean there is so much to do…so we resign ourselves to just doing what we can"* (4th year student interview)

> *"We treat all our patients the same regardless…. And ...I think we are doing an OK job.. well at least the best we can do."*
> (RN interview)

Discussion:

This study explains the behaviours of students and RNs when caring for culturally and linguistically diverse patients, adding to our understanding of factors influencing gaps in nursing care. The uniqueness of this study lies in its explanation of how participants used a raft of disengagement strategies, but more importantly how they became resigned and indifferent to gaps in care. Although disengagement was intentionally used to get through the day with as little conflict as possible, participants did not intentionally set out to provide substandard care. Care was prioritised in terms of tasks, rather than being holistic and person centred, resulting in what is defined in the broader nursing literature as 'missed care' (Bagnasco et al., 2017; Gibbon and Crane, 2018). However this study explains the process of how students and RNs become complacent and indifferent to the needs of culturally and linguistically diverse patients, despite articulating their desire to provide quality care. Participants were aware of the importance of providing culturally sensitive care, which concurs with other studies (Halabi et al., 2018; Wang et al., 2018). However the realities of applying those core principles to their daily practice was challenging, demonstrating the power of the clinical environment in shaping expectations of standards of care.

This study contributes to our understanding of how nurses' ethnocentric attitudes and practices become acceptable and their obligations to provide quality, person centred care are sometimes ignored. This clearly reflects the complexities of translating healthcare reform policy to an increasingly busy and under resourced clinical setting, where nurses feel ill-prepared, over-stretched and overwhelmed. However, this study also provides evidence of

the collective indifference demonstrated and highlights how culturally insensitive behaviours and gaps in care can become rationalised into day-to-day normality and embedded in organisational cultures and practices. Although not generalisable, these findings may have wider implications for nursing practice in general as evident by the increasing calls for compassionate care (Papadopoulos et al., 2016) and addressing missed care (Blackman et al., 2018). Participants were content with taking measures to meet physical care needs and maintenance of physiological safety, but were less concerned with psychological and individual cultural needs. Despite the growing evidence around missed care, participants in this study were either oblivious to their omissions of care or chose to ignore them, highlighting the need for more culturally responsive practice and leadership. While acknowledging the contexts and constraints experienced, the ease at shifting the blame as opposed to taking personal responsibility for gaps in care, the lack of questioning of practices and the complacency at providing substandard care, are significant findings that warrant further consideration. Nurse educators and managers need to work collaboratively in building capacity and capability for providing culturally responsive services.

The data also reveals how culturally insensitive behaviours were observed but went unchallenged. Echoing Curtis (2014), participants described how it was easier to comply with accepted practices, even if that contradicted personal beliefs and nursing values, further contributing to a collective acceptance of substandard care. Drawing on the seminal work by Festinger (1957) who refers to this as 'cognitive dissonance' where individuals feel compelled to comply with practices despite knowing what they should be doing, is useful in understanding such behaviours. These findings mirror Husbands' (2010) description of 'moral professional complacency' and Horsburgh and Ross (2013) account of 'institutionalised negativity'. Having a range of excuses for substandard care helped ease discomforts, but also perpetuated the acceptance of culturally insensitive and gaps in care. Blaming culture as a means of self-preservation is reported in the wider literature (O' Connor et al., 2011). However, Jones et al. (2016) argues that the acceptance of poor nursing care has received little attention. This study highlights that this learned behaviour becomes acceptable and engrained in day to day practices, subsequently sustaining cultural insensitivity and gaps in care. In this way, participants were not just passively tolerating substandard practices, but in doing so were actively perpetuating cultural insensitivity.

Limitations:

This study took a retrospective view of participants' self-reported accounts of their experiences, which may have been influenced by recall bias. Although theoretical saturation was achieved, it must be acknowledged that the number of RNs who volunteered to participate was less than that of student nurses. Although different data collection methods were used, in the absence of direct observations in practice, it is possible that participants' accounts of how they acted and behaved in practice may have been different in reality. A deeper exploration involving participant observation would be beneficial. Focused research is needed to investigate the extent to which disengagement and indifference is evident, when caring for all patients or when nurses are faced with uncertainty about clinical conditions, new treatments or procedures. There is a need to compare perspectives of nurses with that of patients in other contexts and countries.

Conclusion:

This paper contributes to the wider global discourse on missed care and presents evidence of gaps in care for culturally and linguistically diverse patients'. The collective nature of disengagement that went unchallenged and sometimes unnoticed, explains nurses' behaviours in a way that has not previously been explored. Organisational constraints and deficiencies in nurse education are challenges that need addressing, but the complacency

and acceptance of gaps in care that is perpetuated by an organisational culture which appeared to have minimal repercussions warrants urgent attention. Effective leadership is needed to cultivate a committed workforce, through understanding factors influencing nurses' behaviours, whilst empowering, nurturing and enforcing quality standards of care.

Implications for Nursing Management:

This study highlights the need for nurse managers to understand nurses' behaviours when caring for culturally and linguistically diverse patients as a means of supporting and empowering collective ways of addressing gaps in care. Resigned indifference explains how nurses were sometimes aware of the implications of gaps in care, but became resigned to and accepting of it. Nurse Managers need to communicate a clearer message of the responsibilities to provide quality person centered care, which acknowledges and respects cultural difference. This message needs to be explicit in mission statements, philosophies of care, policies and procedures at both organisational and departmental levels. Attention should be paid to celebrating and sharing good practices, but there also needs to be more explicit accountability. Strategies that nurture a supportive culture where the importance of values based behavior and practice is essential, in particular exploring ways of replacing; indifference with commitment and compassion; uncertainty with curiosity and complacency with courage to question practices.

The evidence of cultural imposition, cultural misunderstanding and complacency highlights the need for strategic leadership in developing structures and systems that promote culturally and linguistically appropriate services (CLAS). The CLAS standards framework is a useful resource that should be used as a criterion against which practice is judged (U.S. Department of Health and Human Services, Office of Minority Health, 2014). This framework stipulates the importance of respecting and responding to diverse patient's health, cultural and language needs and preferences. However, there is a need for greater investment in preparing nurse managers for their transformational role, supporting them with leadership and cultural competence training.

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Table 1. Focus Groups Demographics and Profile of Informants:

		Work Area	Gender	Position
Professionally Registered Nurses	Focus Group 1	Medical (2) Surgical (2) Specialised (4)	Female (8)	RGN *(5) CNM I *(3)
	Focus Group 2	Medical (3) Surgical (1) Specialised (2)	Female (5) Male (1)	RGN *(4) CNM I *(2)
Student Nurses	Focus Group 1	Programme Y1 (6)	Female (6) Male (0)	1st Year Student
	Focus Group 2	Programme Y1 (5)	Female (5) Male (0)	1st Year Student
	Focus Group 3	Programme Y2 (9)	Female (7) Male (2)	2nd Year Student
	Focus Group 4	Programme Y2 (6)	Female (4) Male (2)	2nd Year Student
	Focus Group 5	Programme Y3 (6)	Female (6) Male (0)	3rd Year Student
	Focus Group 6	Programme Y3 (7)	Female (7) Male (0)	3rd Year Student
	Focus Group 7	Programme Y4 (9)	Female (7) Male (2)	4th Year Student
	Focus Group 8	Programme Y4 (9)	Female (8) Male (1)	4th Year Student

Table 2. Interview Demographics and Profile of Informants:

	Age	Gender	Position
Professionally Registered Nurses	22 – 29 (4) 30 – 39 (2) 40 – 49 (3) 50 – 59 (1)	Female (10)	RGN *(8) CNM I *(2) CNM II *(1)
Student Nurses	17-23 (16) 24-40 (4)	Female (16) Male (4)	Programme Y1 (4) Programme Y2 (4) Programme Y3 (7) Programme Y4 (5)

RGN* Registered General Nurse
CNM I * Clinical Nurse Manager 1
CNM 11* Clinical Nurse Manager 2

Table 3 Interview schedule:

Student nurse interview schedule	Registered nurse interview schedule
• What experiences have you had of providing care or witnessing the provision of care to patients from different cultural or linguistic backgrounds. What influenced you to think or behave the way you did? • What was good/not good about the care provided? Why? • Did you have any concerns or experience any challenges when caring for or learning how to care for patients from different cultural and linguistic backgrounds? Why? • How did you deal with/respond to them? What factors influenced you to follow that course of action? Why? • Is there anything you would have done or could have done differently? Tell me more…. • Is there anything else you would like to share?	• Tell me about your experiences of caring for or supervise caring for patients from diverse cultural and linguistic backgrounds? Tell me more. • Tell me more about your experiences. What issues emerged for you? How did you cope? • What influenced you to think or behave the way you did? Is there anything you could have done or should have done differently? Is there anything you might do differently now? Tell me more….. • What challenges/concerns do you have if any when caring for culturally and linguistically diverse patients? • How do you deal with these in your daily practice? What influences actions/omissions of care? • Is there anything else you would like to share?