CULTURE-SENSITIVE/PATIENT-CENTERED ASSESSMENT AND CARE PLANNING SKILLS IN HOME HEALTH NURSING

by

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A Dissertation
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of
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DEDICATION

This work is dedicated to:

Home health nurses everywhere in their quest to provide caring, culture-sensitive/patient-centered care to all their patients;

And to their home health patients, all of whom are entitled to equitable, high-quality care, no matter the many ways they differ from their nurses;

And to everyone who works for health justice.

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LIST OF ABBREVIATIONS

CCC.....culturally competent care
CS/PC .....culture-sensitive/patient-centered
CSC..... culture-sensitive care
HHN .....home health nurse
OASIS..... Outcomes and Assessment Information Set
PCC.....patient-centered care
PDGM.....Patient Driven Grouping Model
TCN.....transcultural nurse

ABSTRACT

CULTURE-SENSITIVE/PATIENT-CENTERED ASSESSMENT AND CARE PLANNING SKILLS IN HOME HEALTH NURSING

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Introduction. Home health patients, who are members of minority and other vulnerable groups, suffer disparate outcomes. Culturally-competent care (CCC) and patient-centered care (PCC) aim to facilitate equitable, high-quality care. Both CCC and PCC share the same priorities and strategies, so they can be merged into one concept: culture-sensitive/patient-centered (CS/PC) care. No research about how home health nurses incorporate either CCC or PCC principles into their assessment and care-planning practices currently exist. This study explored "*What is the process by which home health nurses develop their culture-sensitive/patient-centered assessment and care planning skills?"*

Methods: Using a multi-method grounded theory design, two subsamples were recruited. Sub-sample one consisted of transcultural nurses (n=9) who participated in a focus group and sub-sample two consisted of home health nurses (n=20) who participated in in-depth, audio-recorded interviews. The purpose of the transcultural group was to

identify characteristics of CS/PC assessment and care planning, which were used to better understand home health nurses' approach to CS/PC skills. Using a semi-structured interview guide, both sets of participants discussed questions such as, their understanding of CS/PC principles, how they developed their skills, how they instilled CS/PC principles into their assessment and care planning activities and the facilitators/barriers to CS/PC practice.

Results. The grounded theory that emerged was that home health nurses learned CS/PC assessment skills along a journey, primarily through a trial-and error process by 'the seat of their pants." The journey began with caring attitudes and caring nurse-patient relationships, which formed the milieu for their experiences with diverse patient populations and their learning of their first CS/PC skills. Some nurses travel further and refine their skills through self-reflection and strong critical and creative thinking skills. However, many nurses felt stymied in their ability to practice their CS/PC assessment and care planning skills by agency and Medicare processes. They perceived these processes and policies as having a negative impact on their ability to practice their CS/PC skills. Only the most resilient nurses were able to continue their journey towards further developing their CS/PC skills in a changing home health care environment.

The study also provided data to answer several other questions, such as what are the characteristics of a CS/PC nurse? These characteristics include: caring and humble attitudes/values; knowledge about self, uniqueness of persons, and norms of populations served; and skills related to forming a caring relationship with the patient, assessing to understand patients as unique cultural, valued persons, and planning care that enhances

the patient's health, well-being and quality of their lives from their perspectives. Additional questions can also be explored with the data collected, such as 1) what the is the relationship of caring to CS/PC care, 2) what are the specific, pragmatic, measurable CS/PC strategies that home health nurses can incorporate into their assessment and care planning skills, 3) how can academic and agency educators support the knowledge needed by nurses in a multicultural world, and 4) home health nurses' perceptions of, and recommendations to ameliorate, barriers to CS/PC practice.

Discussion. If we accept that CCC and PCC are key elements of high-quality, equitable care, the grounded theory process – *Home Health Nurses' Journey to CS/PC Assessment and Care-Planning Skills* - may help home healthcare clinicians, administrators, educators and policy-makers identify impact points for enhancing CS/PC practices. For instance, nurse clinicians may use the CS/PC attitudes, knowledge, and skills as a blueprint for their professional development, educators my wish to highlight how nurses can incorporate CS/PC strategies into their practice, and administrators may wish to consider ways to minimize barriers and promote nurse resilience.

CHAPTER ONE – INTRODUCTION

Minority patient populations in the United States suffer healthcare disparities (Agency for Healthcare Research and Quality, 2003-2018; Institute of Medicine, 2003). Minority groups are frequently marginalized and stigmatized, putting them at risk for sub-optimal care (White & Stubblefield-Tave, 2016). Disparate patient outcomes are not only associated with race and ethnicity, but also with language (Institute of Medicine, 2003), religion (Padela & Curlin, 2013; Samari et al., 2018), socioeconomic status (Agency for Healthcare Research and Quality, 2018; Haider et al., 2015), age (Schroyen et al., 2016), gender (Wisdom et al., 2010), sexual orientation/gender identification (Roche & Keith, 2014; Sabin et al., 2015), mental and physical disabilities (e.g., deafness, developmental disorders, spinal-cord injuries; Krahn, Walker, & Correa-De-Araujo, 2015; Whiteley, Kurtz, & Cash, 2016), and stigmatized diagnoses (e.g., HIV, obesity, mental illness, substance abuse; de Jacq & Norful, 2016; Von Hippel, Brener, & Von Hippel, 2008; Waller, Lampman, & Lupfer-Johnson, 2012).

Repeatedly, research studies have indicated that minority/marginalized/ stigmatized patients experience suboptimal clinical outcomes, more adverse events, and less satisfaction with care than majority populations, even when controlling for other factors (e.g., access to care, social determinants of health, etc.). Disparities are also costly. LaVeist and colleagues, (2011) report that between 2003 and 2006, the costs of

racial/ethnic disparities alone were estimated to be $230 billion in direct medical costs and $1 trillion in lost productivity between 2003 and 2006.

According to the few studies conducted in home health care, disparities were as likely in the home healthcare setting as in other settings. In a systematic review of racial/ethnic disparities in home health care, Narayan & Scafide (2017) found that all of the relevant studies (N=7) concluded that minority patients were more likely to experience poorer outcomes than white, non-Hispanic majority patients (Agency for Healthcare Research and Quality, 2014, 2018; Brega et al., 2005; Davitt, 2012; Fortinsky et al., 2014; Madigan, 2007; Ryvicker et al., 2012; Smith et al., 2015). In more recent studies, (Chase et al., 2017, 2018) also found racial/disparities in functional outcomes and adverse events. Our search of the research literature located no studies that were focused on other minority/marginalized/vulnerable home health patients (e.g., characterized by sexual orientation/gender identity, disability, stigmatized diagnosis, etc.). Still, it seems likely that home health patients in these vulnerable groups are as likely to experience disparities as they experience in other settings (de Jacq & Norful, 2016; Krahn et al., 2015; Roche & Keith, 2014; Sabin et al., 2015; Von Hippel et al., 2008; Waller et al., 2012; Whiteley et al., 2016).

Home health nurses may have a substantive role in decreasing disparities in home care. Multiple factors may cause healthcare disparities, such as systematic/environmental factors (e.g., accessibility and affordability of care, social determinants of health) and patient factors (e.g., cultural norms, health literacy, and understanding of illness). Further, provider/clinician factors also contributed to disparities (Institute of Medicine, 2003;

Office of Disease Prevention and Health Promotion, 2014; University of Maryland School of Public Health, n.d.). Among these clinician factors are a lack of the attitudes, knowledge and skills needed to provide appropriate, culture-sensitive and patient-centered care needed by culturally diverse patient populations (Butler et al., 2016; Campinha-Bacote, 2011a, 2011b; Epstein & Street, 2011; Hall et al., 2015; Landers et al., 2016; Narayan, 2017, 2019; Tello, 2017). It could be that with additional education and training in the knowledge, attitudes, and skills needed for culturally-competent and patient-centered care, home health nurses may be able to help reduce home healthcare disparities.

Culturally-competent and patient-centered care have been championed as care practices that can improve patient outcomes by the Institute of Medicine (2001, 2003), the federal government (Office of Disease Prevention and Health Promotion, 2019; Office of Minority Health, 2013; United States 111th Congress, 2010), accreditation and quality initiatives (Community Health Accreditation Program, 2019; Institute for Healthcare Improvement, 2016; The Joint Commission, 2010, 2014, 2018), standards and ethical codes of nursing and home health nursing (American Nurses Association [ANA], 2014, 2015b, 2015a) and research studies and expert opinions (Berwick, 2009; Berwick et al., 2008; Betancourt et al., 2005). At the clinical level, culturally-competent care and patient-centered care have been proposed to be, essentially, the same care practices (Darnell & Hickson, 2015; Lor et al., 2016a; Saha et al., 2008). Indeed, a review of the literature indicates that each term can be defined in terms of the other:

- Culturally-Competent Care: respectful, individualized, patient-centered care that meets the patient's needs and preferences and right to equitable care (Office of Minority Health, 2018)
- Patient-Centered Care: respectful, individualized, culture-sensitive care that meets the patients' needs and preferences and right to high-quality care (Institute of Medicine, 2001; Landers et al., 2016)

Because of this interdependent relationship, the term 'culture-sensitive/patient-centered care' can be defined as respectful, individualized care that meets patients' needs and preferences and their right to high-quality, equitable care. Culture-sensitive/patient-centered care has two primary principles: 1) clinicians respectfully listen to and care about their patients' values, goals, needs and preferences; and 2) clinicians partner with their patients to develop care plans that enable patients to feel 'well cared for.' These two principles should characterize clinicians' assessment and care planning skills for high-quality, equitable care to be achieved.

Gaps in the Literature

Although the literature underscores how healthcare disparities could be related to clinician-related factors, it does not expound upon these clinician-related factors in home health nursing. And, although culturally-competent and patient-centered care are proposed as vital methods for overcoming disparities and poor-quality care, the literature is silent as to how home health nurses translate these recommendations into specific, realistic, and measurable care practices. While assessment and care planning are among the key skills that nurses use to provide effective and satisfying care to their patients, the

literature does not describe how home health nurses incorporate culture-sensitive/patient-centered care principles into their assessment and care planning practices. Finally, there are only a small number of studies that mention a few personal, conditional or situational factors that facilitate – or inhibit – culture-sensitive/patient-centered assessment and care planning practices in home health nurses' quest to provide equitable and high quality care to all patients in our diverse society.

Significance

Culture-sensitive/patient-centered assessment and care practices may be able to increase equity and quality outcomes for culturally diverse patient populations, helping to rectify the immorality of healthcare disparities in the United States. Actions to decrease disparate outcomes may reduce the costs of inequitable healthcare outcomes – morbidity, mortality, adverse events, hospitalizations, lost productivity – estimated to be about $330 billion a year (LaVeist et al., 2011). Care that is culturally-sensitive and patient-centered is likely to increase the satisfaction of patients, families and caregivers, which in turn is likely to increase patient engagement and adherence to mutually agreeable treatment recommendations. Nurses' work satisfaction may increase when more effective care improves patient outcomes. Care practices that have the potential to decrease disparities are of interest to federal/state healthcare regulators, accreditation programs, and public/private payers. Specifically, improved care practices may have implications for nursing clinicians/educators/researchers/leaders and, more importantly, for home health patients seeking optimal outcomes for their health and well-being.

Purpose of Study

The purpose of this study was to acquire knowledge that may help home health nurses enhance their assessment and care-planning skills in order to attain equitable, high-quality care for all patients.

Research Question/Specific Aims

The research question for this study is: *What is the process by which home health nurses conduct culture-sensitive/patient-centered assessments and care planning?* Specifically, the aims of this study were:

- to uncover the culture-sensitive/patient-centered care assessment and care planning practices of home health nurses; and
- to identify the facilitators and barriers (personal, situational, and contextual factors) that influence the process of conducting culture-sensitive/patient-centered assessment and care planning.

Conceptual Framework

Corbin and Strauss (2015) suggested that a grounded theory researcher approaches data analysis with a 'beginner's mind,' rather than through the lens of a theoretical framework. Looking at the data with 'new eyes' is how the grounded theory researcher may uncover novel concepts and relationships and generate a new substantive theory. However, science builds on previous knowledge, and the researcher must acknowledge when theoretical models and assumptions have influenced their thinking. My thinking about concepts inherent in the research question – the purpose and values of

cultural competence, patient-centeredness and nursing's relationship with patients – are congruent with Ray's Theory of Transcultural Caring Dynamics (2016)

Ray's *Theory of Transcultural Caring Dynamics* (2016)

Foundations of the theory. Ray incorporates knowledge and multiple theories from science, philosophy, and nursing into her theory. The theory emerges from five dynamic areas of knowledge: complexity science, wisdom traditions, nursing's simultaneity/unitary-transformative paradigm, transcultural nursing, and caring science and theory. Complexity science includes evolutionary theory, relativity theory, quantum physics, holographic systems theory, and chaos theory (Davidson, Ray & Turkel , 2011). Complexity science sees the human being as an energy field in mutual process with the environment's energy field (Rogers, 1994) with profound implications for nursing. Wisdom traditions contain insights about an Ultimate Source, which underlies the interconnectedness of everyone and everything, giving meaning and dignity to all. Nursing's simultaneity/unitary-transformative paradigm sees human beings from a perspective congruent with complexity science, as championed by Rogers' (1994) Theory of Unitary Human Beings, Newman's (1997) Theory of Expanding Consciousness, Parse's (1992) Theory of Human Becoming and Watson's (2009) Theory of Human Caring.

Researchers in the field of transcultural nursing, first championed by Leininger (1988), consider culture as a key element in the development of each person, becoming an essential element of the person's identity and needs (Andrews et al., 2020; Giger & Haddad, 2020; Purnell & Fenkl, 2021; Ray, 2016). The field of caring science and theory

in nursing has been developed by Leininger (1988), Swanson (1991), Boykin & Schoenhofer (1993), Watson (1999) and Roach (2002), among others. They place caring as the core element in nursing practice. Ray's theory emerges out of these five bodies of knowledge/perspectives.

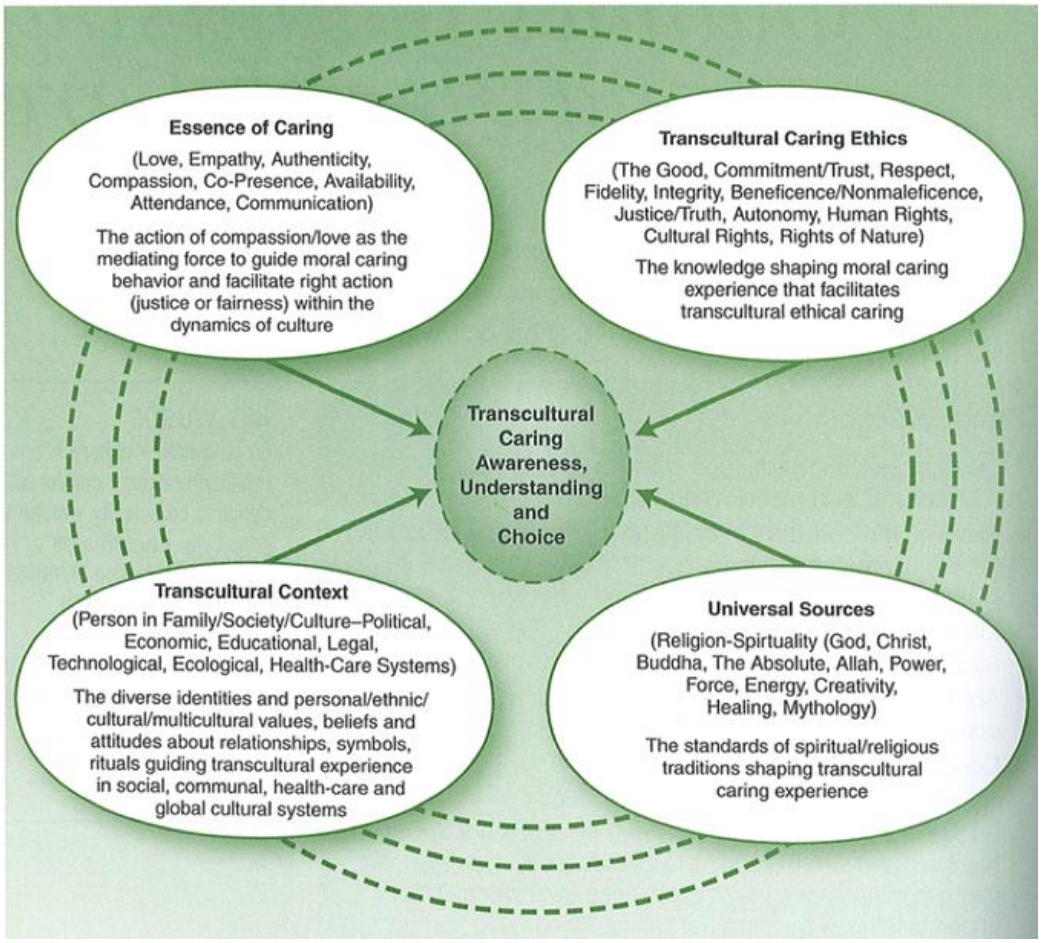

Figure 1: Model of Transcultural Caring Dynamics in Nursing and Health Care

Dimensions of the Theory. Ray's Theory and Model of Transcultural Caring Dynamics consists of four dimensions that contribute to the 5th dimension. These dimensions include 1) essence of caring, 2) transcultural caring ethics, 3) transcultural context, and 4) universal sources, which together enable the nurse to practice the 5th and central concept – transcultural caring awareness, understanding and choice – during the care of each patient. Each of the four concepts are deeply interconnected and so the concepts are each defined in relation to the other concepts. See Appendix A for a detailed description of Ray's Theory and Model of Transcultural Caring Dynamics.

Relationship of Ray's Theory to Study. My nursing philosophy is congruent with Ray's Transcultural Caring Dynamics Theory. With its emphasis on the concept of transcultural caring, which embeds the concepts of culturally-competent care and patient-centered care, the Transcultural Caring Dynamics theory articulates how I think about the influence that culture-sensitive/patient-centered care is likely to have on home health nurses' assessment and care planning practices. Ray's theory is also consistent with the proposition that culturally-competent care and patient-centered care are crucial to effective nursing assessments and care-planning, and that at the clinical level, culturally-competent care and patient-centered care are the same phenomenon with different names. Both culturally-competent care and patient-centered care use very similar, if not identical, caring strategies to achieve excellent care.

Assumptions

The approach to this research study is based upon several assumptions that are fundamental to the theoretical approach. The assumptions are:

1. Culture-sensitive care and patient-centered care are synonymous, describing the same care construct.
2. Culture-sensitive/patient-centered assessments and care planning contribute to the delivery of culturally-sensitive and patient-centered care.
3. Delivering nursing care that is culture-sensitive and patient-centered contribute to equitable and high-quality care.

Conceptual Definitions

Home health nurses are registered nurses who provide skilled care to patients where they live. The goal of home health nurses is to help patients achieve their highest potential for physical, psychosocial, spiritual and functional health or peaceful death. (ANA, 2014).

Home health patients need professional nursing care where they reside to achieve their optimal level of health and well-being. Home health patients may be at any stage of life, with any type of diagnosis or condition, and of any type of majority/minority group (ANA, 2014).

Culture refers to the beliefs, values, practices, and behaviors that patients have acquired through the multiple societal groups that have influenced them. Every person is a cultural being, with individualized cultural needs and preferences (Campinha-Bacote, 2015; Ray, 2016).

Culturally diverse patients: Patients who are members of groups that differ from majority/normative groups. Culturally diverse groups can be conceptualized by race, ethnicity, language, religion, socioeconomic status, age, gender, sexual orientation,

gender identity, stigmatized diagnoses, physical or mental disabilities, and other ways in which people differ from societal norms. All patients belong to multiple cultural groups and, almost always, each patient is a member of several minority groups.

Culture-sensitive/patient-centered care is respectful, individualized care, in which the nurse listens carefully to the patient's values, goals, and preferences and works with the patient as an equal partner in planning care, with the goal of achieving equitable high-quality care (Beach et al., 2006). It is centered on the patient's goals and values (not the medical system's/nurse's preferences) and promotes the patient's holistic health and well-being.

Home health nursing assessments. Assessments that focus on all the physical, psychosocial, functional and environmental factors that can affect the patient's health and well-being, including cultural beliefs, values, practices and behaviors. (ANA, 2014).

Home health nursing care planning. Based on a comprehensive assessment, the nurse identifies all the relevant factors that are affecting or could affect the patient's health and well-being. In collaboration with the patient/family/caregiver, the nurse and patient work together to develop a mutually agreeable plan of care. (ANA, 2014).

Chapter One Summary

A mounting body of evidence indicates there are disparities in health care, including in home health care. Two initiatives have been championed to enable all patients achieve equitable and high-quality outcomes: culturally-competent care and patient-centered care. Home health nurses may have an important role in achieving better outcomes for their patients through the expert practice of culture-sensitive/patient-

centered care. By asking “What is the process by which home health nurses conduct culture-sensitive/patient-centered assessments and care planning?” this study sought to gain knowledge about the attitudes, knowledge, and skills associated with culture-sensitive/patient-centered care and how home health nurses provide culture-sensitive/patient-centered assessments. This investigation was designed to generate a theory of how home health nurses develop their culture-sensitive/patient centered skills and identify factors that promote or inhibit culture-sensitive/patient-centered care practices.

CHAPTER TWO – LITERATURE REVIEW

The research question for this proposed study is "*What is the process by which home health nurses conduct culture-sensitive/patient-centered assessments and care planning?* Embedded in the question are several concepts: home health nursing, assessment and care planning practices, culture-sensitive care (usually labeled 'culturally competent care'), patient-centered care, and the concept of culture-sensitive/patient-centered care as a merged concept. The literature about each of these concepts is reviewed below. The review first focuses on the general nursing literature and subsequently focuses on home health nursing studies.

Home Health Nursing

The American Nurses Association's (ANA, 2014) most recent *Home Health Nursing: Scope and Standards of Practic*e defined the roles and responsibilities of home health nurses in the United States, providing guidance for nurses' practice. The ANA document defined home health nursing as "a *specialty area of nursing practice that promotes optimal health and well-being for patients, their families and caregivers within their homes"* (p. 5). Home health nursing includes intermittent skilled nursing care, specialty nurse care (e.g., maternal-child, pediatrics, intravenous therapy, etc.), hospital-at-home, private duty, care management, and palliative/hospice care, among other innovative home-based healthcare programs. The *Scope and Standards* document stated that home health nurses use a holistic approach that empowers patients/families/ caregivers to manage health problems in their own homes so they can reach their highest

levels of physical, functional, and psychosocial health. The *International Guidelines for Home Health Nursing* (International Home Care Nurses Organization, 2017) are congruent with the standards developed by the ANA, and make strong statements of the importance of culturally competent and patient-centered care in home health nursing.

When patients receive care in facilities (e.g. hospitals), they leave their own environment and enter the Western healthcare environment. In home health nursing, however, the nurse enters the patient's environment and is a guest in the patient's home, which has many implications about how home health nursing is different from care in other settings. Home health nurses demonstrate respect for the patient by respecting the patient's personal and cultural norms while within the patient's home. Home health nurses cannot 'control' what patients do in their own homes; nurses can only help the patient achieve health and well-being goals by developing a trusting relationship with the patient as an equal partner (Marrelli, 2016). Such partnerships are built on nurses' acceptance of – and honoring of – the patient's personal/cultural lifeways (DiCicco-Bloom, 2000). Other distinguishing characteristics of home health nursing include autonomy, independence, adaptability, flexibility and creativity (ANA, 2014; Gorski & Narayan, 2017).

Hospital-based nurses may be supported by a team of fellow nurses and other health providers with valuable experience or skills. In the home health setting, nurses practice independently and frequently are the only provider caring for their patients; therefore, nurses need advanced skills in assessment, care planning, care coordination, and patient education/coaching (ANA, 2014). However, current basic nursing education

programs may not adequately prepare nurses for the demands of home health nursing, which is increasingly important as care shifts from facilities to community/home-based care (Jarrín et al., 2019). The independent nature of home health nursing requires advanced skills in culture-sensitive/patient-centered assessment and care planning.

Assessment in Home Health Nursing

According to the *Home Health Nursing: Scope and Standards of Practice* (ANA, 2014), home health nurses are responsible for providing a comprehensive patient assessment, which includes relevant factors that could affect the patient's health and well-being. According to the document, factors to be assessed include 1) physical factors (comprehensive physical/body systems, medication knowledge/adherence, nutrition intake); 2) psychosocial factors (cognitive, emotional, cultural, linguistic, spiritual, financial, family/caregiver/social relationships and support, health literacy and health knowledge); 3) functional factors (activities of daily living [ADLs], instrumental ADLs, risk for falls, patient/environment interface); and 4) environmental factors (safety of home and neighborhood, sanitation, infection control). Assessment of the patient's personal/cultural values, beliefs, goals, needs, and preferences is a crucial element of the psychosocial assessment because they are important to the patient's emotional well-being (Narayan, 2019b). Decisions about the depth and breadth of each of the components depends upon the patient's diagnoses, reason for being in home health care, the anticipated length of stay, and other factors (Narayan, 2018).

Care Planning in Home Health Nursing

According to the ANA's *Scope and Standards* document, the nurse is expected to review the comprehensive assessment data and identify the physical, psychosocial, functional, and environmental factors that are affecting – or could affect – the patient's health and well-being. In collaboration with the patient/family/caregiver, a plan of care is developed to meet the patient's values, goals, and preferences; the plan is to be grounded in the patient's cultural perspective about life and healthcare. The plan of care includes ongoing assessments, teaching/coaching activities, direct nursing care skills/procedures, and referrals for ancillary and community resources. Standard care plans and evidence-based guidelines are to be adapted to achieve care that is culturally congruent/comfortable for the patient and professionally appropriate for the clinician (Gorski & Narayan, 2017).

Culturally-Competent Care

In the profession of nursing, the emergence of cultural competence initiatives primarily grew out of Leininger's (Leininger & McFarland, 2006; Leininger, 1988) body of research and the multiple studies based upon her *Culture Care Diversity and Universality Theory.* The theory sought to explain health and illness experiences from the perspective of one's ethnic identity or affiliation with other cultural groups. Numerous nursing textbooks about cultural competence are available, such as those by Andrews and colleagues (2020), Chesnay & Anderson (2019), Giger & Haddad (2020), McFarland & Wehbe-Alamah (2018), Purnell & Fenkl (2021), and Ray (2016). Most of the textbooks, and much of the published research, have focused on either cultural competence

principles or describing cultural norms characteristic of specific cultural groups. There is scant literature that translates research findings (i.e. cultural knowledge) into specific, measurable actions that nurses could implement to increase their skill at providing culture-sensitive care to a wide range of culturally diverse patients. Furthermore, the relevant literature (e.g. Narayan, 2002, 2003, 2010) is aging and may no longer be aligned with the needs of contemporary nurses.

Some nursing studies have examined the effectiveness of cultural competence education or the barriers nurses face in attempting to meet the needs of culturally diverse patients. For example, Delgado et al. (2013) and Debiasi and Selleck (2017) investigated the effectiveness of short training programs on staff nurse and nurse practitioner cultural competence; both reported finding that the programs were effective at increasing cultural awareness. However, a corresponding increase in cultural skill was either not significant or was not measured. Another example is Hart & Mareno's (2014, 2016) studies – one quantitative, one qualitative – which focused on nurse perceptions of their cultural competence and the barriers they encounter when trying to integrate it into their practice. In their quantitative study (2014), nurses self-reported moderate levels of cultural awareness, but perceived themselves to have low levels of knowledge, skill, and comfort in providing culturally competent care. In the qualitative study (2016), nurses reported that there were too many cultural groups to learn about, that they didn't have the support or resources needed for meeting the needs of culturally diverse patients, and that a patients' inability to speak English and low levels of health literacy prevented the nurses

from providing good care to these patients. Studies like these illustrate that nurses have difficulty in translating cultural awareness into culturally-competent nursing skills.

The American Nurses Association (2015) includes a standard in the *Nursing: Scope and Standards of Practice, 3rd edition,* that states "The registered nurse practices in a manner that is congruent with cultural diversity and inclusion principles" (p. 69). The American Academy of Nursing and the Transcultural Nursing Society (2011) jointly developed the *Standards of Practice for Culturally Competent Nursing Care* (Douglas et al., 2011) and the American Association of Colleges of Nursing (2019) has issued relevant competencies and toolkits for basic and graduate nursing education. However, most of the guidelines and related literature has focused on outlining cultural principles or increasing awareness and knowledge. For example, the Registered Nurses' Association of Ontario (2007) has developed widely-used, best-practice guidelines for cultural competence. However, these guidelines are limited to increasing cultural awareness and knowledge or improving communication skills; a wide range of relevant skills (e.g. assessment and care-planning skills) are not addressed in the document.

Cultural Competence in Home Health Nursing

With the assistance of a health research librarian, a literature search was conducted to locate research studies that investigated cultural competence in the home health nursing setting. The search was limited to the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database, using the subject heading terms of *home nursing professional* and *cultural competence* or *cultural diversity*. Key terms and their variations were also used, such as, *home health nursing, home care nurse, home*

healthcare, cultural competence, culturally competent care, and *culturally diverse populations*. The search was limited to research studies published in English between 2000 - 2019. Ancestry searches were also conducted. After screening abstracts, relevant studies were reviewed. Eligible studies focused on professional home health nurse samples whose purpose was to explore culturally competent home health nursing skills, processes, or behaviors; alternatively, articles that described facilitators or inhibitors of culturally competent care practices were included.

Although there were articles in the home health literature about cultural competence and caring for culturally diverse patients, these articles primarily focused on the cultural needs and preferences of specific ethnic, religious, or other vulnerable groups (e.g., Elliott, 2018; Grady, 2014; Miner, Liebel, Wilde, Carroll, & Omar, 2018). Others described educational programs to increase cultural awareness (Mager & Grossman, 2013) or quality improvement, evidence-based projects that translated findings from research conducted in other nursing settings (Romeo, 2007; Woerner et al., 2009). A search of the literature resulted in no articles related to the *skills* and *processes* home health nurses might use to meet the needs of the wide range of diverse patient populations they are likely to encounter in their practice.

Ultimately, only three research articles (Debesay, Harsløf, Rechel, & Vike, 2014; DiCicco-Bloom & Cohen, 2003; Schim, Doorenbos, & Borse, 2006) and one published conference abstract (Bjarnadottir, Bockting, & Dowding, 2016) were located. Appendix B lists the characteristics of each of these four studies. The three studies used a qualitative design (interviews, observations, and/or focus groups) and one used a

quantitative design (Schim et al., 2006). Three studies were conducted in the United States, and one in Norway (Debesay et al., 2014). One study of hospice nurses (Schim et al., 2006) was included because both home health nurses and hospice nurses make home visits and share many of the same practices. None of the studies directly addressed home health nurses' assessment and care planning practices.

The study most relevant to this proposed study was conducted by DiCicco-Bloom & Cohen (2003). They explored the attitudes of, and processes used by, home health nurses when caring for patients of culturally diverse populations. They used a rigorous qualitative process of not only interviewing nurses (N=14) but also observed each of the nurses' interactions with one immigrant patient over three visits. Subsequently, they categorized the nurses' interactions into one of three categories: 1) no awareness/acknowledgement of patient's cultural needs/preferences; 2) an ethnocentric awareness, with negative judgments of cultural differences; and 3) awareness of and sensitivity to cultural differences. Only three of the 14 nurses exhibited attitudes and behaviors that placed them in the awareness/sensitivity category and none of the three possessed the skills or resources needed to effectively adapt the care plan to meet the patient's specific cultural needs/preferences. The researchers concluded that nurses did not know how to incorporate culturally competent care principles into their daily practices.

Schim et al. (2006) investigated factors associated with higher levels of hospice nurse cultural competence. In this cross-sectional descriptive study, hospice nurses (N=107) completed the *Cultural Competence Assessment Tool* (Schim et al., 2003) to

measure the nurse's diversity experiences, cultural awareness/sensitivity, and behaviors associated with cultural competence. Regression analyses found that higher education was associated with higher cultural awareness and sensitivity; also, diversity training was associated with higher self-reported cultural competence behaviors. The authors also reported that the cultural competence behaviors with the lowest scores included 'performing and documenting cultural assessments' and 'adapting care to patients' cultural needs/preferences.'

Debesay et al. (2014) explored the challenges that visiting nurses encounter in providing care to the growing immigrant/refugee population of Norway. They used a qualitative, hermeneutical approach to conduct semi-structured, in-depth interviews with Norwegian nurses (N=19). The visiting nurses felt their Norwegian and nursing norms differed from the norms of their immigrant patients, especially as related to intimate care between genders and the nature of 'good' rehabilitation and palliative care practices. Nurses felt personally inadequate in caring for these patients. The researchers also concluded that the agencies for which the nurses worked were responsible for structural barriers to good nursing care for culturally diverse patients; the agencies did not provide the education, resources, or support that the nurses needed to meet the needs of their patients.

In a focus group study of home health nurses (N=14), Bjarnadottir and colleagues. (2016) investigated nurses' attitudes toward asking patients about their sexual orientation and gender identity as part of a comprehensive assessment. They found that nurses were reluctant to ask about sexual orientation and gender identity because they didn't know

how to ask the question without causing offense. Further, the nurses reported not having enough knowledge about sexual orientation/gender identity healthcare issues to make the question 'useful' in their practice.

Summary of Culturally Competent Care in Home Health Nursing Studies

The review of the literature indicates very little is known about the culturally competent care practices of home health nurses. Limitations of these four studies included small sample sizes from limited geographic areas (Bjarnadottir et al., 2016; Debesay et al., 2014; B. DiCicco-Bloom & Cohen, 2003) and reliance on self-reported data (Schim et al., 2006). And for one of studies (Bjarnadottir et al., 2016), only the abstract was available, which did not provide sufficient information to judge the rigor of the study. However, these few studies suggest that nurses tend to have limited awareness and knowledge about the potential impact of culture on their patients' health care experience and that nurses tend to see their patients' cultural lifeways through a judgmental and ethnocentric lens. Even when nurses were aware and sensitive to the impact that cultural differences may have on a patient's healthcare priorities and practices, they often did not know how to incorporate cultural competence principles into their practice. Additional evidence indicates that education and training on cultural competence may increase knowledge and attitudes, but a lack of agency/structural support and resources may inhibit the delivery of culturally appropriate care. There were no research studies that identified culturally-competent assessment and care planning processes for home health nurses.

Patient-Centered Care

Although patient-centered care has long been championed by nurses (Morgan & Yoder, 2012; Nightingale, 1859; Peplau, 1992; Watson, 1999), most studies exploring the processes and outcomes of patient-centered care as a specific method of care are found in the medical literature (Fix et al., 2018a; Frampton et al., 2008; Lown et al., 2011; Ospina et al., 2019). Multiple definitions of patient-centered care have been proposed (Frampton et al., 2008; Institute of Medicine, 2001; World Health Organization, 2015), and most definitions are in agreement that two key practices are crucial to patient-centered care: 1) listening to – and caring about – what is important to the patient, and 2) adapting care to the patient's goals, values, and preferences. Some definitions include the formation of a therapeutic relationship (trusting, caring clinician-patient relationship) as an important element.

Although the nursing literature uses the term 'patient-centered care' ubiquitously; the term is frequently used as a descriptive connotative term and remains a poorly conceptualized nursing phenomenon (Hobbs, 2009; Sidani et al., 2014). However, patient-centered care is implied in the work of the many caring theorists (Boykin & Schoenhofer, 1993; Leininger, 1988; Roach, 2002; Watson, 1999). Several nurses have attempted to operationalize the concept. Boykins (2014) described various communication strategies that characterize patient-centered care. DiGioia, Lorenz, Greenhouse, Bertoty, and Rocks (2010) described how they operationalized patient-centered care in a hospital setting. Molony, Kolanowski, Van Haitsma, & Rooney (2018) discussed patient-centered assessment and care planning activities for dementia patients

in nursing facilities. The Registered Nurses' Association of Ontario (2015) developed patient and family-centered 'best practice' guidelines based upon a systematic review and collection of expert opinions.

After performing a concept analysis, Morgan and Yoder (2012) proposed a definition for patient-centered care: "a holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care (p. 8).

McCormack and McCance (2006) have developed a nursing research-based theory of patient-centered care that highlights the constructs of patient-centered care in nursing. Their mid-range theory is grounded in caring science and conceptualizes patient-centered care as consisting of four constructs:

1. *prerequisites*, which focus on the attributes of the nurse;
2. *care environment*, which focuses on the context in which care is delivered;
3. *person-centered processes*, which focus on delivering care through a range of activities;
4. *expected outcomes*, which are the results of effective person-centered nursing. (p. 475)

To date, they have also published the sole nursing text focused on patient-centered care (McCormack & McCance, 2017).

Ultimately, in the nursing literature, patient centered-care emerges as a concept that is characterized by at least two main elements: 1) empathic listening to the patient to understand the experience of the health problem from the patient's perspective, and 2) ensuring that the patient's perspective guides clinical decision-making (de Witte, Schoot, & Proot, 2006). These elements rest within a therapeutic relationship (Morgan & Yoder, 2012). The first component – listening – is related to nursing assessments and the second component – shared decision-making – is related to patient-centered care planning. To date, the American Nurses Association, the American Academy of Nursing, and the American Association of Colleges of Nursing have not specifically defined 'patient-centered care' nor developed standards for its practice. Still, the American Nurses Association's *Scope and Standards* for nursing (2015) and home health nursing (2014) used the term 'patient-centered care' throughout their documents.

Patient-Centered Care in Home Health Nursing

The search of the literature for patient-centered care in home health nursing was limited to research studies published in English after 2000 in the CINAHL database. The search included CINAHL's subject heading terms, *home nursing, professional* and *patient centered care* and key term alternatives for *home health nurses/nursing*, and *patient-centered care*. The search included both American and British spellings [centered and centred] and other terms comparable to *patient-centered* such as *client-centered* and *person-centered*. A review of the abstracts led to the identification of articles that were likely to be relevant to this search. Then, ancestry searches were conducted, and half the articles included in this review were found through ancestry searching, especially those

using alternative terms for patient-centered care, such as *tailored care, patient empowerment,* and *practice partnership*. Subsequently, the relevant research studies were retrieved and reviewed for research reports that met the eligibility criteria: 1) samples were primarily professional home health nurses; 2) the purpose of the study was to explore patient-centered home health nursing skills, processes, and behaviors or the study identified facilitators or inhibitors of patient-centered care practices.

A final sample of six studies met the search criteria. See Appendix C for the characteristics of the studies. All the studies were conducted outside the United States; there were no studies of patient-centered care in home health nursing conducted in the United States. All the reports noted that the concept is poorly understood in nursing practice; hence, all the studies employed a qualitative design. No studies exploring how patient-centered values were specifically adopted into home health nurses' assessment and care planning processes were located.

In a series of three grounded theory studies, Schoot and colleagues studied 'client-centered care,' 'demand-oriented care,' and 'tailored care' (using the terms interchangeably) in a small sample of chronically-ill/disabled Dutch home healthcare patients, their caregivers and their nurses. In their first two studies (N=8 and N=7), Schoot, Proot, Meulen, & de Witte (2005a, 2005b) explored clients' perceptions of care. Participants felt that tailored care treated them as unique individuals and that the nurses cared about their emotional needs and adapted their care to patient/family values and lifestyles. They felt that their relationship with the nurse was a partnership, characterized by equality and interdependence. Patients also felt that nurses who delivered care tailored

to their clients' wishes/expectations were attentive, responsive, and promoted patient autonomy by sharing professional knowledge, so the patient felt adequately informed to make good care decisions. Participants felt nurses faced barriers to providing this kind of care because of the task-orientation of nursing systems, protocols nurses were required to follow, and heavy workloads they could not control. They felt that the most client-oriented nurses partnered and dialogued with the patient to create a balance between patient's desires and systemic barriers.

In their third study, Schoot and colleagues (2006) explored Dutch nurse/aide (N=10) perceptions of client-centered care. Nurses felt their responsibility to provide client-centered care was in competition with their agencies' expectations for productive, efficient, and cost-effective employees and with their responsibilities to provide care based on evidence-based guidelines. The researchers recommended that nurses dialogue, negotiate, compromise, and think creatively with their clients to meet patient and professional/agency goals.

Brown, McWilliam, & Ward-Griffin (2006) conducted an interpretive phenomenological study of the practices of Canadian home health nurses (N=8) whose agency had adopted a client-centered empowerment approach to care a year earlier. The agency initiatiive focused on giving the patient the power to direct care planning decisions. Despite receiving training on a flexible, client-driven care delivery approach, the nurses struggled with how to partner with patients in creating effective care plans. Nurse perceived barriers to the process included regulatory and financial constraints, centralized control over nursing schedules and practices, documentation burdens, and

workloads that did not give them the time needed to meet the values of client-centered empowerment care. Furthermore, most nurses did not seem to know *how* to share power with the patient and were more comfortable with the 'power over' expert approach to care planning rather than the sharing 'power with' the patient that was the core of the initiative.

Leine, Wahl, Borge, Hustavenes, & Bondevik (2017) interviewed Norwegian home healthcare patients with chronic obstructive lung disease (N= 6) to determine patients' experiences with 'partnership as practice' nursing care; this patient-centered care framework expects nurses to use caring behaviors within a therapeutic relationship with the patient. They found that patients felt that nurses who 'partnered' were respectful, valued them as unique persons, and listened carefully to understand their illness experiences. Patients also reported that the nurses created a trusting/caring relationship, dialogued with them, gave them the information needed to make care decisions, and provided support by believing – and believing in – the patient. Having received this kind of care, the patients reported feeling safe, motivated, and comfortable.

Róin (2018) performed a secondary analysis of selected qualitative data collected about patient perceptions on aging in the Faroe Islands (Denmark). The researcher examined the data to uncover elderly patients' (N=6) descriptions of the patient-centeredness of home health services. The study found that patients perceived having little say in *when*, *how*, and *what* services were provided to them, even when they had different preferences and needs than those the nurses used to develop the care plans. The nurses matched services to the resources they had readily available rather than to the

patients' expressed needs. Róin concluded that the nurses did not give adequate attention to the principles of patient-centeredness such as listening and enabling the patients' needs and preferences.

Summary of Patient-Centered Care in Home Health Nursing Studies

The six studies were limited by their small sample sizes; further, some samples included auxiliary nursing personnel or selective patient samples that were not representative of the larger home health patient population. Because the studies were conducted with nurses, patients/families, or caregivers from predominantly northern European countries, they could reflect ethnic/cultural values and practices that differ from those that characterize American home health care. The decision to include alternate terms for patient-centered care in this literature review may have contaminated the data with nuanced, but significant conceptual differences in the application of the patient-centered care concept. Nonetheless, the studies examined characteristics of patient-centered care at a universal level. They validated the two elements frequently found in the medical and general nursing literature: listening to the patient's values, goals, and preferences and adapting the care plan to promote patient comfort, well-being, and satisfaction. Further, the research reinforced the central role of developing a trusting, caring therapeutic relationship when delivering patient-centered care in the home health care setting.

Culture-Sensitive/Patient-Centered Care

In this proposed research, the concepts of culturally-competent care and patient-centered care are merged into one concept. The literature suggests that the two concepts have the same goals and care practices; therefore, a merger of the two concepts in

practice and education may be beneficial to helping nurses achieve equitable high-quality care for home health patients.

Saha, Beach and Cooper (2008) outlined the historical evolution of the cultural-competence and patient-centered concepts, analyzing their similarities and differences. They suggested that the principles and operationalization of cultural competence and patient-centered care overlap with one another to such an extent that they may be merged into one method to promote better care for all patients. They concluded that:

At the core of both patient centeredness and cultural competence is the ability of the healthcare provider to see the patient as a unique person; to maintain unconditional positive regard; to build effective rapport; to use the bio-psychosocial model; to explore patient beliefs, values and meaning of illness; and to find common ground regarding treatment plans (p. 7).

Still they found that each initiative has some unique elements. For example, cultural competence stresses the vulnerability of patients from minority groups and the need for effective communication despite differing languages. Patient-centered care stresses the importance of therapeutic communication strategies, such as providing unconditional positive regard and understanding the person from a holistic perspective. However, Saha and colleagues noted the strengths of each initiative are needed by the other initiative.

There has been growing support to combine the concepts of cultural competence and patient-centered care. The Joint Commission (2010) issued recommendations for *Advancing Effective Communication, Cultural Competence, and Patient- and Family-*

Centered Care: A Roadmap for Hospitals. In the document, they combined cultural competence and patient-centered recommendations under the different phases (e.g., admission, assessment, discharge, etc.) of a patient's hospital stay. Similarly, Tucker and colleagues (2007) combined the two concepts in their model – the *Patient-Centered Culturally Sensitive Health Care Model* – to promote better care for patients seeking psychological counselling. Subsequently, Tucker, Marsiske, Rice, Nielson, & Herman (2011) reported that implementing the model's merged culturally-competent and patient-centered care strategies improved patient adherence to recommendations and achieved better patient outcomes. Darnell & Hickson (2015) also advocated for combining cultural competence and patient-centered care approaches to achieve high-quality nursing care for America's multicultural population. Finally, based upon nursing research studies, Lor, Crooks, & Tluczek (2016) analyzed the attributes, antecedents, and consequences of four concepts: *person-centered care, patient-centered care, family-centered care* and *culturally competent care*, identifying their similarities and contributions to improved nursing care. The authors integrated their findings into the development of the *Person-, Family-, Culture-Centered Nursing Care Model.*

Terminology

In this proposed study, the term 'culture-sensitive/patient-centered care' is coined to signify the merged concept of cultural competence and patient-centeredness. But many different terms are used for 'patient-centered' and 'cultural competence' in the literature and each of the terms has its own nuances. For instance, 'client-centered care' seems to emphasize a transactional relationship, in which customer satisfaction is the goal (Brown

et al., 2006). ‘Family-centered care’ sees every patient in relationship with their families and caregivers, such that patient illness affects the health and well-being of the whole family/caregiver unit (Kuo et al., 2012). ‘Person-centered care’ emphasizes the dignity that each person has by virtue of his/her shared humanity with the nurse (Hennessey, 2015). ‘Patient-centered care’ carries the nuance of the moral obligation nurses have to their patients, as described in the *Code of Ethics for Nurses* (ANA, 2015a). Of these options, the term ‘patient-centered care’ was determined to be the best fit for this study, as it is the term used in the *Home Health Nursing: Scope and Standards of Practice* (ANA, 2014), a document that defines ‘patient’ as referring to the patient’s family, significant others, and caregivers.

The decision not to use the term ‘cultural competence’ is intentional as there are several critiques of the term or its associations. The term ‘competence’ may imply that one has reached a sufficient level of knowledge and skill, which is in opposition to the dynamism and diversity of patients’ cultures (Campinha-Bacote, 2015). Cultures are dynamic, everchanging, and infinitely numerous. Additionally, the concept of intersectionality (every individual is a member of multiple cultural groups – age, gender, race/ethnicity, socioeconomic status, sexual orientation/gender identity, etc.) means that each individual is a unique amalgam of cultural beliefs, values, behaviors, and practices (Fitzgerald & Campinha-Bacote, 2019). These phenomena indicate that the nurse could never achieve ‘competence’ in knowing a patient’s culture. Becoming culturally competent is not a skill that can be achieved and checked off. Instead, the nurse is always

in a process of learning how to be sensitive to each patient as a unique cultural being (Campinha-Bacote, 2011).

Tervalon & Murray-Garcia (1998) believe 'cultural competence' has an arrogant connotation. They recommended that the goal is 'cultural humility.' Dreher & MacNaughton (2002) cautioned that many nurses assume that cultural competence only means knowing a lot about the patient's culture and that such an approach may increase the risk of stereotyping patients and discouraging nurses who may feel an inability to master the prerequisite cultural knowledge for the multitude of cultural groups that they encounter in their practice. Other terms have been suggested, including *culturally comfortable care, culturally congruent care, culturally concordant care, culture-sensitive care*, among others. The term 'culture-sensitive care' implies that the nurse cares about the patient as a cultural being and desires to be sensitive to the patient's values, goals and preferences. Ultimately, the term '*culture-sensitive/patient-centered care'* was chosen to identify the knowledge, attitudes, practices and skills needed for equitable, high-quality nursing care.

Chapter Two Summary

A review of the literature indicated that although culture-sensitive care and patient-centered care practices are crucial to home health nursing practice (ANA, 2014, 2015a), there is very little research exploring either culturally-competent care or patient-centered care in home health nursing. No studies were located that described how culture-sensitive care or patient-centered care principles are incorporated into home health nurses' assessment and care planning processes. The literature review also revealed that

culture-sensitive and patient-centered care principles and processes are intrinsic to one another, and that they could be integrated and conceptualized as *culture-sensitive/patient-centered care*.

CHAPTER THREE – METHODOLOGY

Design

A multimethod qualitative approach was used to explore the concept of culture-sensitive/patient-centered assessments and care planning in home health nursing. When a phenomenon is poorly understood, a qualitative study is usually the most appropriate research approach (Creswell & Poth, 2018). And when the research question asks a process question, such as, how home health nurses develop their culture-sensitive/patient-centered assessment and care-planning skills, the question is usually best answered with a grounded theory research approach (Creswell & Poth, 2018). The descriptive phenomenological approach, appropriate to "explore, analyze and describe phenomena" (Matua & Van Der Wal, 2015, p. 23), was used to identify several phenomena embedded in the grounded theory data, such as culture-sensitive/patient-centered care characteristics and 'best practices. The sample included two subsamples: one for interview participants and one for focus group participants.

Scientific Rigor

Corbin and Strauss (2015) recommend procedures and techniques for assuring the scientific rigor of a grounded theory study. Qualitive study rigor demands trustworthiness. Trustworthiness in qualitative studies is analogous to the 'reliability and validity' criteria used in quantitative studies. Trustworthiness includes strategies to enhance the credibility, dependability, confirmability, and transferability of the findings (see Appendix D). In addition, grounded theory studies include additional specific

strategies that further promote the trustworthiness of this study design, such as, theoretical sampling, maximal variation sampling, constant comparative analysis, reflective memoing, and expert checks, among other techniques that promote trustworthiness. All these strategies were employed in the conduct of this study.

Ethical Considerations

This study involves human subjects, so the criteria within the Common Rule 45 CFR 46 (Office for Human Research Protections, US-DHHS, 2016) were used to assure the participants were protected from potential harm. Specific strategies for assuring patient rights in this study are outlined in Appendix E. This study was approved by the George Mason University Office of Research Integrity and Assurance (GMU IRBNet Number: 1450243-1). Participants provided informed consent before data collection began. (See Appendices F for and G for Consent Forms).

Sample

The target population for this study was home health nurses who perform patient assessments and care planning. The study had two subsamples of participants. Subsample 1 consisted of transcultural nurses, who participated in a focus group discussing culture-sensitive care and patient-centered care in their practice. Subsample 2 consisted of home health nurses, who participated in in-depth face-to-face interviews.

Subsample 1. The focus group of transcultural nurses consisted of nurses attending the Transcultural Nursing Society's 2019 annual conference. They were considered 'transcultural nursing experts' by virtue of their interest in and commitment to excellence in cross-cultural nursing care, as evidenced by their participation in the

conference. (See demographic table in Appendix H.) The group consisted of White, female nurses (N=9), from different parts of the country (eastern, western, and southern regions of the United States; one nurse from Canada). The average age of the sample was 48 years, with a range of 29 – 71 years. The participants were highly educated, holding PhD (n=2), DNP (n=1), or MSN (n=6) degrees. They held various certifications, including four who obtained certification as transcultural nurses. The sample included clinical educators (n=4), nurse practitioners (n=3), and clinical nurses (n=2; practicing in in the medical-surgical and public health settings). Overall, the sample averaged 26 years of nursing experience, with a range of 4 to 50 years. Four nurses had home health nursing experience that ranged from 3 to 16 years. The purpose of the transcultural nurse sample was to provide insight into the culture-sensitive/patient-centered practices of nurses in the home health setting.

Originally, we planned to conduct two other focus groups. One for home health specialists (clinical experts, quality experts, educators) and the second for home health nurse leaders (administrators, supervisors, policy makers). The purpose of these expert focus groups, like the group conducted with transcultural nurses, was to elucidate their perspectives about what culture-sensitive/patient-centered assessment and care planning are and their importance in home health nursing practice. However, these two focus groups were cancelled due to inadequate participation. However, expert and leader perspectives were subsequently included by expanding the criteria for Subsample 2 so their viewpoints were included in the data. A fourth focus group consisting of home health nurse clinicians from a single agency was proposed. The purpose of this group was

to discuss and critique the emerging theory. However, this focus group had to be cancelled due to COVID-19 restrictions and stresses related to the recent initiation of the new Patient-Driven Groupings Model (PDGM) payment system.

Subsample 2: The second sample consisted of home health nurses. Eligible participants were home health registered nurses (RNs) in the United States who had at least one year of home health experience. Although at the start of the study, inclusion criteria required the nurses to manage a caseload of diverse patients, this requirement was expanded to include nurses who supervised or educated home health nurses managing caseloads, because of problems recruiting them into focus groups. Still, these supervisors and educators made up a quarter of the sample, and most made assessment and care planning visits as needed by their agencies. Patient caseloads were presumed to be diverse because of the multiculturalism within patient populations, because there are so many ways to be culturally diverse, and because all patients are cultural beings with their own personal cultural needs and preferences. The criteria for at least a year in home health care was required because research indicates it takes at least a year for a nurse new to home care to become a competent home health nurse (Neal, 1999; Neal-Boylan, 2008). All participants were able to communicate in English and, being professional nurses, were over 18 years old.

Ultimately, the interview sample of home health nurses (n=20) were primarily White females, but with one Black and one male nurses. See demographic table in Appendix I.) These nurses were recruited from 11 states in the Northeast, Southeast, Midwest, Southwest and Western regions of the country. About two-thirds of the

participants were employed by for-profit agencies, with the remainder working for non-profit agencies. Their average age was 52.5 years (range: 25 to 68 years). Four nurses had ADN degrees, 11 had a BSN, and 5 had an MSN or allied health master's degree; nine participants were certified in diverse nursing specialties. Most of the nurses in the sample worked as case-managing clinicians, though some had supervisory, educational, or quality assurance roles on a part-time or full-time basis. In their personal lives, five participants relayed significant experiences with people of diverse races/cultures (i.e., parents or spouses) or extensive experience working in another country or with a distinctive cultural group. The nurses averaged 13 years (range: 1 to 45 years) of home health nursing experience.

Recruitment

The focus group and interview participants were recruited using different methods. Subsample 1 were recruited at the 2019 Transcultural Nursing Society annual meeting. A date, time, and private room for the group session was arranged with the conference organizers. Flyers (see Appendix J) specified the study's purpose, eligibility criteria, the meeting time and place and incentive for participation (lunch and a $10 Amazon gift cards).

Subsample 2, the interview participants, were purposively recruited with flyers posted on websites (see Appendix K), but also through snowball strategies. The researcher contacted the leaders of multiple national and local organizations and agencies. Organizations were asked to post the study's IRB-approved digital flyer on their websites, and agency leaders were asked to post, distribute or e-mail (as per agency

protocols) the flyer to their agency's nurses. A digital flyer was also posted on a Facebook discussion group for home health nurses.

Participant Selection

Nurses interested in the transcultural nurse focus group (Subsample 1) convened in the meeting room at the specified time. The potential participants completed a short form privately which was reviewed immediately to determine eligibility. All interested participants were checked-in to the session. After explaining the study and answering questions, the nine participants signed the consent forms and returned them to the researcher.

The potential home health nurse participants (Subsample 2) sent an e-mail to the researcher, expressing interest in the study, the researcher contacted each nurse by phone to discuss the study, to answer questions and to obtain initial demographic information to assure eligibility and to promote maximal variation within the sample. If potential participants met the eligibility and variability criteria, and if they were still interested in participating in an interview, the researcher set up an appointment with the nurses. Although the original intent was to meet in-person with participants who lived within a 50-mile radius, this plan was abandoned (after the first 8 interviews) in March 2020 due to COVID restrictions. Subsequently, all interviews were conducted via the online Webex or Zoom platforms.

The initial home health nurse participants were purposively recruited to represent broad insights and opinions about assessing and planning care for culturally diverse patient populations. As the interviews continued, recruitment efforts focused on maximal

demographic variation of the sample. Because the development of a grounded theory was one of the goals of the study, theoretical sampling was employed to help elucidate theoretical themes emerging from the data. Recruitment of new participants continued until feasible variation of the sample was obtained and the data became saturated in breadth and depth, indicating additional interviews were unlikely to provide any new relevant data to complete the theory under construction. The subsample ultimately included 20 nurses of diverse ages, genders, race/ethnicities, and geographic regions in the United States. They also were diverse in educational preparation, years in home health nursing and in the type of agencies where they worked.

Informed consent was obtained from all participants before interviews began. A copy of the consent was sent to each participant as part of the researcher's initial contact with the potential participant, so it could be reviewed and discussed during the initial telephone contact. The provisions of the consent were discussed with the participant during the initial contact, encouraging the potential participant to express any questions or concerns. The potential participant was also encouraged to contact the researcher by phone or e-mail with any additional questions. For local nurses interviewed before March 2020, the consent was reviewed and signed at the start of the face-to-face meeting. For nurses whose interviews were conducted on-line, the participant signed and sent the consent, and the researcher received it, prior to the online interview.

Data Collection

Data collection procedures for focus group and interview participants were guided by the methodology and techniques recommended by Corbin & Strauss (2015). Before

collecting the data, the researcher mindfully attempted to identify and bracket all assumptions and expectations. The researcher sought to maintain objectivity, unconditional positive regard, and respect for the participant's needs and preferences throughout the interviews with focus group members individual interview participants. The researcher met each participant/focus group in a private setting to protect participant confidentiality. For online interviews, participants were advised to find a quiet private room for the interview, and the researcher was also in a similar setting. Upon starting the focus group/interviews, the researcher thanked the participants, and made comments designed to build rapport, inspire trust, and promote sharing during the focus group/interview process. Focus group members were instructed to respect the confidentiality of other group members at the beginning and end of the discussion.

Consistent with grounded theory procedures, the researcher initiated the focus group/ interviews with open-ended questions. Care was taken to avoid leading questions. The interview guide (see Appendix L) lists examples of questions that were posed to participants. Standard probes were used to encourage participants to fully describe their thoughts, feelings, and practices related to their assessment and care planning activities

. At the conclusion of their participation, the researcher gave or mailed each participant a $10 Amazon Gift Card in appreciation for their time and effort. The focus group met for 90 minutes. The interviews lasted between 50 – 75 minutes.

Data Management

The researcher assigned a pseudonym to each participant to protect the participant's confidentiality. All notes, recordings and transcripts were labeled with the

pseudonym. Data was secured as required by George Mason University's research policies. A dedicated password-protected computer was used to store transcripts, memos, digital recordings, and relevant data. Signed informed consents are stored to a locked office in the College of Health and Human Services, George Mason University. Only the research team (researcher and dissertation committee chair) had access to the study information. Audio files will be destroyed at the completion of this dissertation defense. Study data and informed consents will be stored for five years after the completion of the study and then destroyed. The de-identified electronic data will be maintained on the password-protected hard drive until publications are completed; all electronic files will be stored in the GMU School of Nursing for a period of five years after the completion of the study. Hard-copy data files will be shredded at the conclusion of a successful dissertation defense.

Data Analysis

Before beginning analysis of the data, the researcher, once again, mindfully bracketed personal assumptions and expectations. All audio files were transcribed verbatim and all personally identifiable information was deleted to protect participants' confidentiality. Transcripts was imported into Dedoose (2018), a web-based application for managing and analyzing qualitative data.

The focus group transcript was analyzed shortly after collection. The data analysis began with open coding, identifying words and phrases relevant to the research question and, subsequently, grouping the chunks of data into initial categories. Subsequently, the progressive axial coding process resulted in the four selective coding categories:

attitudes, knowledge, skills, and facilitators/barriers. Finally, the overall themes were identified by reflecting about how nurses' attitudes and knowledge informed their skills.

The home health nurse interviews were analyzed with grounded theory procedures. Thus, data analysis began with the first interview and continued throughout the study in an iterative process. Analysis techniques included constant comparison, memoing, and open/axial/selective coding of interview and focus group data (see Appendix M). Reflective memos were included in the analysis to uncover relationships between the themes and categories in the data.

Specifically, the analysis began by fragmenting the data from the first interview with open coding. Subsequently, each interview was coded and compared to the data in previous interviews in an iterative process. As the study matured, data was categorized into axial codes. During the selective coding process, four themes emerged relating the axial categories to each other. As the analysis matured, the attitudes, knowledge, and skills of the transcultural nurses were compared with those of the home health nurses to enrich the understanding of home health nurses' skill development along a continuum.

Eventually, this process enabled the researcher to identify the attitudes, knowledge, skills, best practices, facilitators and barriers of culture-sensitive/patient-centered care in the home health nursing context. The grounded theory approach to data analysis enabled the researcher to explain how the concepts unearthed from the data were related to one another. As a result, the researcher uncovered a theoretical process about how home health nurses learn culture-sensitive/patient-centered skills and identified ways in which this process might be improved.

CHAPTER FOUR – MANUSCRIPT 1

This chapter summarizes descriptive findings from the transcultural nurse focus group discussion. Because the literature contains so little research about how nurses in any setting conduct culture-sensitive/patient-centered assessment and care planning activities during their daily care of patients, the first step in this grounded theory study was to investigate how transcultural nurses (nurses expert in culture-sensitive/patient-centered care) incorporate these concepts into their daily practice.

The transcultural nurses were highly educated in, and highly committed to, the principles of transcultural nursing practice, which are manifested in culture-sensitive/patient-centered care skills. What emerged from the data were not only the skills these nurses used, but also the attitudes and knowledge that supported these skills. These findings (along with the literature) enabled me to better recognize and understand home health nurses' attitudes knowledge, skills and assessment and care-planning practices. The transcultural nurses' attitudes, knowledge and skills are reported in the paper below, which is in review at the Journal of Transcultural Nursing.

Transcultural Nurse Views on Culture-Sensitive/Patient-Centered Assessment and Care-Planning: A Descriptive Study [Paper 1]

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Abstract

Introduction. Together, culture-sensitive (CS) and patient-centered (PC) care are considered essential to achieve high-quality equitable care. The purpose of this study was to determine how nurses incorporate CS/PC care into their assessment and care planning practices, especially for culturally-diverse and marginalized patients. ***Methodology.*** A descriptive study, using the focus group method, was conducted at the October 2019 Transcultural Nursing Society Conference. Participants (n=9) discussed how they instilled cultural sensitivity and patient-centeredness into their assessment and care planning skills***. Results.*** Participants revealed attitudes, knowledge, and skills associated with CS/PC assessment and care planning. They also identified specific strategies for translating CS/PC theory into assessment and care planning practices. ***Discussion.*** Caring emerged as a unifying concept integrating three principles to achieve CS/PC assessments and care planning**.** ***Conclusions***. Nurses seeking to translate CS and PC theory into practice may adopt the pragmatic CS/PC assessment and care planning strategies promoted by transcultural nurses.

Keywords: assessment & care planning, caring, culturally competent care, patient-centered care, transcultural nursing, cultural diversity, culturally diverse patients/populations

Introduction

Nurses endeavor to provide high quality, equitable care to all patients. Nonetheless, the Institute of Medicine (IOM) concluded that patients were not consistently receiving high quality care (IOM, 2001) and that racially/ethnically diverse patients were experiencing disparities in health outcomes (IOM , 2003). The IOM's expert panels proposed patient-centered care (PCC) as one of the keys to quality care (IOM, 2001) and suggested culturally competent care (CCC) as the key to equitable care (IOM, 2003; Office of Minority Health, 2000). In response to the IOM recommendations, various organizations have incorporated PCC and CCC principles into their practice standards and guidelines to improve the quality of care, patient satisfaction and/or patient outcomes. These organizations include the American Academy of Nursing and the Transcultural Nursing Society (Douglas et al., 2011, 2014), American Nurses Association, (2015, 2019), Institute of Healthcare Improvement (2016), Office of Minority Health (2013) and the Joint Commission, (2010), among others. Yet, little is known about how nurses incorporate PCC and CSC principles into their assessment and care planning practices.

Literature Review. The concept of PCC is grounded in nursing's caring literature (Boykin & Schoenhofer, 1993; Boykins, 2014; Leininger & McFarland, 2006; McCormack & McCance, 2017; Nightingale, 1859; Ray, 2016; Roach, 2002; Swanson, 1991; Watson, 2008). The concept of CCC is explicated in the transcultural nursing literature (Andrews et al., 2020; Giger & Haddad, 2020; Leininger, 1988; Lincoln, 2017; McFarland & Wehbe-

Alamah, 2018; Purnell & Fenkl, 2021; Ray, 2016; Spector, 2017). CCC is needed not only for patients of diverse races and ethnicity, but also for patients of other minority and vulnerable groups. Populations whose cultural norms or lifeways differ from the 'expected' norms of the majority population (e.g. due to age, gender, sexual orientation, gender identification, socioeconomic status, education, occupation, mental/physical disability, stigmatized diagnoses, etc.) also need nurses who can provide CCC to meet their particular healthcare needs (Narayan, 2020).

Reviews of PCC and CCC initiatives suggest that PCC and CCC are so clinically similar they are inherent to one another (Beach et al., 2006; Darnell & Hickson, 2015; Lor et al., 2016; Saha et al., 2008). For example, the Joint Commission (2010) united the two concepts in their recommendations for how hospitals can advance cultural competence and patient/family-centered care. Ray (2016) integrated PCC and CCC concepts into a philosophical model - Transcultural Caring Dynamics for Nursing and Health Care. Although CCC focuses on equitable care (IOM, 2003; Office of Minority Health, 2013), and PCC focuses on high quality care (IOM 2001), they both seek to achieve respectful, individualized care that addresses the patients' needs and preferences.

The term 'culturally competent care' has been criticized. 'Competence' may connote that someone has achieved a body of knowledge or a skill ; yet, becoming 'culturally competent' is an ongoing process (Campinha-Bacote, 2015). Claiming to be 'competent' in the cultural needs of others may be perceived as arrogant or having a

lack of humility (Campinha-Bacote, 2018; Dreher & MacNaughton, 2002; Tervalon & Murray-Garcia, 1998). Furthermore, the focus of the CCC term is on the skills of the care provider (self-centered) rather than the needs of the patient (patient-centered). Thus, the term, 'culture-sensitive care' (CSC) may be the more appropriate term to use. Furthermore, since CSC and PCC are inseparable – inherent to one another – tying both concepts into a single term seems appropriate. Therefore, throughout this paper, we use the term "*culture-sensitive/patient-centered* (CS/PC)" care. This combination term describes care that is respectful and individualized to each patient. It also implies care designed to meet patients' needs and preferences, while advancing their right to *high-quality, equitable* care. Henceforth, the term "CS/PC" care will be used through the remainder of this paper to describe care that is both culturally-sensitive and patient-centered.

The extant literature lacks research on how nurses incorporate CS/PC principles into their daily patient assessments and care planning. Instead, research has indicated that many nurses – even nurses who have received cultural competence education – feel uncomfortable, insecure, or incompetent translating their cultural sensitivity and knowledge into assessment and care planning skills (Debiasi & Selleck, 2017; Delgado et al., 2013; Hart & Mareno, 2014; 2016). Campinha-Bacote (2015) has found 'skill' is one of five attributes defining the cultural competence journey. Yet, the research above has shown that even when nurses demonstrate the other four attributes of Campinha-Bacote's model – desire, awareness, knowledge and encounters – a significant number

of nurses are unable to translate these attributes into specific, realistic, and measurable assessment and care planning skills in their daily patient encounters.

Study Purpose. This paper describes the first component of a grounded theory study investigating how home health nurses incorporate CS/PC care principles into their daily assessment and care planning practices. In this component, a focus group of transcultural nurses was used to determine how they translated their cultural commitment and knowledge into CS/PC assessments and care planning. The findings from this focus group (along with the literature) helped to frame the cultural sensitivity and patient-centeredness of home health nurses' care in the second component of the larger study. The research question for the focus group was: *How do transcultural nurses translate CS/PC knowledge into their clinical assessments and care planning?*

Methodology

Design, setting, recruitment. A qualitative descriptive design, using the focus group approach, was used for this study. The study was approved by George Mason University's Institutional Review Board (GMU IRBNet Number:1450243-1). The focus group was convened at the October 2019 annual conference of the Transcultural Nursing Society. Flyers were placed close to the conference registration table to invite nurses' participation in the study. Interested participants met in a private room within the conference facility for the 90-minute, audio-recorded discussion.

Sample. The participants (n=9) were "transcultural nurses" by virtue of their participation in the Transcultural Nursing Society's conference; attendance implied that they valued the importance of culture to patient health and well-being. Four of these nurses were certified transcultural nurses. The participants were all female and self-identified as White. The average age of the sample was 48 years, with a range of 29 – 71 years. Geographically, the participants came from the eastern, western, and southern regions of the United States; one nurse was from Canada. The sample was highly educated; the participants held PhD (n=2), DNP (n=1), or master's degrees (n=6). The participants were clinical educators (n=4), nurse practitioners (n=3), or were clinical nurses practicing in medical-surgical (n=1) or public health (n=1) settings. Overall, the sample averaged 26 years of nursing experience, with a range of 4 to 50 years. Four nurses had home health nursing experience that ranged from 3 to 16 years.

Data Collection. The first author (MCN) facilitated the focus group. The participants were informed that the purpose of the focus group was to better understand the skills transcultural nurses use to provide CSC in busy clinical situations. Participants were also informed that the information they provided would be used to help understand the cultural sensitivity home health nurses could bring to their patient assessment and care planning activities. A brief interview guide contained open-ended questions and standard probes to encourage elucidation and clarification of responses. The facilitator encouraged participants to describe CS and PC assessment and care planning behaviors, discuss the relationship between the concepts of CS care and PC

care, and consider the facilitators and barriers that helped or hindered their ability to provide CS/PC care to their patients.

Analysis. The audio file was transcribed verbatim. During this process, all personally identifiable information was deleted to protect the participants' confidentiality. The transcript was imported into Dedoose (2018), a web-based application for managing and analyzing qualitative data. The data analysis began with open coding, identifying words and phrases relevant to the research question and, subsequently, grouping the chunks of data into initial categories. Subsequently, the progressive axial coding process resulted in the four selective coding categories: *attitudes, knowledge*, *skills,* and *facilitators/barriers*. Finally, the overall themes were identified by reflecting about how nurses' attitudes and knowledge informed their skills.

Results

The goal of this component of the study was to identify how transcultural nurses translate their knowledge of CS/PC care principles into their daily assessment and care planning practices. The participants engaged in a robust discussion, building on one another's comments and enriching the data with their differing perspectives. It was clear that these nurses used strategies associated with patient-centered care to provide culturally-sensitive care. The participants described the relevant *attitudes* (Table 1), *knowledge* (Table 2), and *skills* (Table 3, 4 and 5) needed for CS/PC patient encounters. Further, the participants identified numerous factors that served as *facilitators*/*barriers* to conducting CS/PC assessments and care planning (Table 6).

Attitudes. The participants believed that nurses need to have a particular disposition to successfully deliver care to diverse patient populations. They identified specific attitudes and values that they felt were the foundation for CS/PC assessments and care planning (Table 1). One participant tied these attitudes and values together under the concept of *caring.* She identified caring as the essence of nursing and an ethical obligation for nurses. Other participants agreed and added that caring is crucial to forming a warm empathetic relationship in which the patient feels appreciated as a unique person. The participants stressed the importance of learning about "the person within the patient," how their patients feel emotionally and how they would like to live their lives. The ability to care deeply about the patient helped the participants provide care that promoted the patient's comfort and develop care plans to which the patient could adhere.

The participants described how they put their egos – their need to appear expert and skilled – aside in an effort to create a human bond with their patients. This approach requires *humility*. Nurses need to be humble enough to acknowledge the shared humanity they have with their patients. They associated humility with risk-taking – stepping outside of one's usual way of doing things – to deliver creative and effective CS/PC care. The nurses admitted that mistakes are likely to occur and that the nurse needs to be humble enough to apologize for them, using the cultural error as an opportunity to learn an alternative approach to patient care. A humble attitude also

allows nurses to establish a collaborative partnership with their patients to achieve optimal health outcomes and a lifestyle that the patient values.

Knowledge. The participants discussed important areas of knowledge that nurses need to provide CS/PC care. They felt that nurses first needed *self-knowledge*, recognizing themselves as cultural beings (see Table 2). Nurses who reflect on their default ways of thinking (and doing) tend to discover they are frequently different from their patients' ways because they spring from the nurses' own cultures. With this understanding of their own cultural norms (beliefs, values, behaviors, practices, assumptions, biases) they can see that their norms are different from – but not 'superior' to – the patient's norms. They can then recognize cultural norms are as important to patients as they are to themselves. Nurses who self-reflect on their own thoughts and behaviors during patient encounters may find it helps them to develop their skills in professional caring, warmth, and empathy.

The focus group participants also believed that nurses should learn about the *cultural norms of the populations they serve,* such as their body language, etiquette, perceptions of time, family roles, among others. While participants felt that the norms of cultural groups provide an important background for patient encounters, they emphasized that nurses need to stay mindful that patients may or may not adhere to the norms of their cultural groups. Nurses must also understand that *each patient is unique*; each individual is a member of multiple cultural groups and has unique life experiences. Participants warned that nurses should never stereotype patients by their

affiliation with ethnic, religious, socioeconomic, sexual orientation/gender identity, or other cultural identities.

Nurses need to know when (and how) to ask patients about their health-related cultural needs and preferences; they need a *framework for applying cultural knowledge into their assessment and care planning practices*. The participants felt that skilled nurses combine relevant cultural knowledge with their clinical judgment to know *which* cultural questions to ask *this* patient, with *this* diagnosis, in *this* setting to assure the most effective, culturally-congruent plan of care. The focus group participants also discussed how knowledge of Leininger's (1988) three modes of care *(cultural preservation/maintenance, accommodation/negotiation,* and *repatterning or restructuring)* were important to their care planning practices. One nurse described how she mentally sorted cultural assessment data into three categories: *health-helpful* (e.g. involvement of family in care), *health-neutral* (e.g., religious/spiritual practices), and *health-harmful* (e.g., high-salt diet) to help in the care planning process. She described how she builds on the helpful to support desired outcomes and aims to change the harmful (e.g., with patient education and coaching) to reduce barriers to improved health. Other focus group participants felt that including neutral practices, that do not affect health outcomes (e.g. religious/spiritual practices), in the care plan is a powerful way to honor the patient's cultural norms.

Skills. The participants identified many specific, concrete, pragmatic strategies they used, despite the busyness of their clinical settings, to assure CS/PC assessments

and care planning. The skills category fell into three distinct sub-categories; that is, the participants described three distinct types of skills they used to practice CS/PC care. These three skills are *relationship-building skills* (Table 3)*, assessment skills* (Table 4), and *care-planning skills* (Table 5). In discussing these three skills, the participants frequently would say, " "*I always*…" and then would identify a strategy. Thus, the participants identified a number of strategies for achieving each of the three skills, which we illustrate with participants' quotes in Tables 3, 4, and 5.

Further analysis of the three skills revealed that the participants' quotes revealed characteristic themes for each skill, Additional analysis uncovered three principles, one for each skill. These themes and principles are also included in Tables 3, 4, and 5. Together the three principles provide an outline for promoting CS/PC assessment and care planning.

The first principle was: *A warm caring nurse-patient relationship provides the milieu for CS/PC assessment and care planning* (Table 3). All participants agreed that effective CS/PC assessment and care planning could only occur within a warm and caring nurse-patient relationship. Thus, the three skills, necessary for providing CS/PC care, were interwoven with one another. The participants discussed 11 strategies they used to demonstrate the three thematic qualities – respect, caring and flexibility – needed to form a caring relationship with their patients.

The second principle was: *Assess to discover and appreciate patients as unique, cultural, valued persons* (Table 4). To actualize this principle the participants identified

another 11 strategies they use to achieve CS/PC assessments. These strategies were characterized by two themes: a patient-centered focus (assess to understand the person within the patient) and a culture-sensitive focus (assess to understand the patient as a cultural being).

Finally, the third principle – *Plan care with patients to enhance patients' health, well-being and lives* (Table 5) – recognizes that the care planning process should be collaborative and should honor the patient's priorities. The goal was to balance the medically-determined goals and evidence-based guidelines with what is important to the patient – their values and desired life-style. These must be honored for the patient to have a sense of well-being and a life worth living. To attain the goal of this principle, the participants identified seven strategies, which were characterized by three themes: share power, build trust, and use theoretical models. The nurses identified three models that guided their care planning processes.

Facilitators and Barriers. The participants focused on identifying the facilitators of, rather than the barriers to, CS/PC assessments and care planning (Table 6). Participants believed that to be CS/PC, nurses need to be grounded in the values discussed in the "Attitudes" section. Thus, they felt that nurses must commit to being self-reflective and caring deeply about how patients feel and experience their health problems. Participants also felt a "good" basic education and ongoing inservices in culture and cultural skills is crucial. They also recommended mentoring and case conferences to educate nurses in ways to be culture-sensitive and patient-centered.

They felt that being exposed to multiple cultures through their lives and work helps nurses develop CS/PC skills. The participants felt that nurses' employers could also facilitate CS/PC care. Organizations that have mission statements, policies, and care delivery models, which honor CS/PC care, supported nurses' ability to provide this care.

On the other hand, the participants felt that the absence or inadequacy of any of the facilitators created barriers to nurses' ability to provide CS/PC assessments and care planning. They felt that many nurses, especially nurses educated prior to awareness about the importance of culture to healthcare, were hampered in providing CS care because they frequently had not had an opportunity to acquire the cultural knowledge and skill needed. Organizations that gave inadequate attention to the quality and equity of care for culturally diverse patients frequently have policies and processes that inhibit CS/PC care. For instance, in order to achieve efficiencies, organizations that did not recognize the importance of caring relationships to effective satisfying care, frequently used care delivery models that fragment care, compromising the ability of nurses to build a relationship with the patient and provide CS/PC care.

Discussion

Our focus group of transcultural nurses identified attitudes, knowledge, and specific strategies that nurses use to provide CS/PC assessments and care planning. We compared these findings with concept analysis papers, systemic reviews, and guidelines related to CS care (Douglas et al., 2014; Henderson et al., 2018; Sharifi et al., 2019) and

PC care (Morgan & Yoder, 2012; Ortiz, 2018; Pajnkihar et al., 2017; Scholl et al., 2014). We found that the participants' array of attitudes, knowledge, and skills were consistent with the literature. Our focus group participants contributed to the literature by offering pragmatic strategies for delivering CS/PC care when conducting nursing assessments and care planning.

Caring as a unifying concept. Throughout the focus group discussion, participants consistently implied, or overtly stated, that *caring* is a key element of their assessment/care-planning attitudes, knowledge, and skills. The participants' emphasis on caring, and how to embody it in practice, echoed the work of numerous caring theorists (Boykin & Schoenhofer, 1993; Boykins, 2014; Leininger, 1988; Nightingale, 1859; Ray, 2016; Roach, 2002; Swanson, 1991; Watson, 1999). Further, the participants' emphasis on caring resonated with the caring principles central to the theories of both Leininger (McFarland & Wehbe-Alamah, 2018) and Watson (2008). Jonsdottir et al. (2004) identified the caring relationship as the core of the of the partnership between nurses and patients, enabling nurses to meet patients "where they are" so they can focus on the patient's concerns (p.241).

The participants asserted that caring attitudes, knowledge, and skills were interdependent, reciprocal, and supportive of one another. For example, one participant spoke about a strategy she uses to simultaneously develop a caring relationship and begin the patient-centered assessment. Instead of asking the generic question "How can I help you?" to open a patient encounter, she acknowledges what she perceives the

patient to be currently experiencing emotionally or physically. This nurse would state "You seem worried?" (or angry, in pain, exhausted, etc.), implying '*I see you and I care about how you are feeling*.' This approach to establishing the nurse-patient relationship suggests that the nurse cares about the patient as a person, and not just as one of the many patients for whom they must perform tasks that day. This strategy may allow patients to perceive the underlying caring the nurse has for the patient. An authentic caring nurse-patient relationship is key to effective assessment and care planning.

CS/PC care as a merged concept. Throughout the focus group discussion, the participants merged the concepts of CS care and PC care together into one concept for nursing practice, as recommended by Darnell & Hickson (2015) and (Lor et al. (2016). Despite an interview guide that asked specific questions about CS practices and separate questions about PC practices, the participants couched the strategies they use to meet one within the context of the other. In nursing, Leininger provided the foundation for CS care and Watson provided the foundation for PC care; however, both used the same concept – caring – as the foundation for their theories. Similar caring strategies are used to meet the goals of high-quality (PC) and equitable (CS) care.

Self-Knowledge. The participants asserted that a critical first step in providing CS/PC care is 'knowing oneself' as a *cultural* being, with one's own cultural values, beliefs, and practices. They stressed that nurses must recognize their own unique cultural patterns before graciously encountering differing cultural beliefs. Self-knowledge is achieved through self-reflection, a highly valued method of learning for

novice nurses (Contreras et al., 2020; Pai, 2016). Self-reflection is a tool for nurses to increase their cultural sensitivity (Douglas et al., 2014; Younas, 2020) and is considered a life-long nursing skill (Morrison & Symes, 2011). With introspection, nurses may understand themselves as unique cultural beings, who can't be stereotyped into the characteristics associated with their cultural group(s). Thus, nurses learn from personal reflection that stereotyping is never appropriate; each individual is a unique amalgamation of intersecting cultural influences, personality traits, and life experiences. In addition, Lincoln (2017) described how knowing one's self as a cultural being enables the nurse to find common ground with culturally diverse patients, increasing the understanding needed to best assess and plan care with the patient.

Risk-taking. Among the attitudes the participants identified as being important to CSC was the willingness to take risks and make mistakes. This willingness requires humility, an important element of CSC (Campinha-Bacote, 2018; Foronda, 2020; Tervalon & Murray-Garcia, 1998). With humility, the nurse focuses more on the needs of the patient than on their own need to be an 'efficient expert.' Humility requires the nurse to let go of ego enough to learn from the patient and to creatively adapt care. The nurse may risk trying untraditional approaches that may - or may not – work. Furthermore, when trying to be culturally sensitive, the nurse may inadvertently say or do something that is offensive; if so, the nurse must be willing to apologize and learn from the patient how to do things better. This may contribute to an equitable, caring relationship. Although risk-taking is not a common theme identified in the CSC and PCC

literature, Morrison & Symes (2011) found it prevalent in the literature related to expert nursing practice. Douglas et al. (2014) also commented on the value of risk-taking as an important value in CS nursing care.

Dueling Sources of Cultural Knowledge. The participants insisted that nurses need to have knowledge about their patients' cultures. They equally stressed the importance of asking the patient about their cultural norms, rather than relying on previously-acquired cultural knowledge. Although nurses need to recognize the cultural norms of the populations they serve, reliance on cultural resources as the sole way to learn about a patient's culture may lead to stereotyping. Nurses need to learn about this particular patient as a unique cultural being.

Nurses may grapple with the tension between these two sources of cultural knowledge. What is the purpose of learning about specific cultures if nurses should always learn about the patient's culture from the patient? The paradox is resolved when nurses understand that the purpose of cultural knowledge is not to pigeonhole patients. Rather, cultural knowledge helps nurses to: 1) understand what they might otherwise misunderstand (e.g., certain hygiene rituals/practices), 2) learn implicit cultural non-verbal communication and etiquette norms (e.g., meaning of avoiding eye contact), or 3) ask effective questions (e.g., values related to pain management).

Cultural assessment. The focus group participants described cultural factors that should be part of patients' assessments. Specifically, they mentioned family dynamics/roles, nutrition, health literacy, and holydays/holidays that may affect CS care

planning. However, despite prompting by the facilitator, the participants did not identify other important cultural factors that have been identified by transcultural scholars/nurses as important to diverse patients' health, well-being and care planning (Andrews et al., 2020; Giger & Haddad, 2020; McFarland & Wehbe-Alamah, 2018; Narayan, 2003, 2010; Purnell & Fenkl, 2021). For instance, depending on the patient's diagnosis and situation, it may be helpful for nurses to assess and understand cultural beliefs and practices related to health maintenance and treatment of illness, pain response and treatment, hygiene and modesty norms, ethical values guiding care of sick and seriously ill, and many other cultural factors that are important to CS/PC care planning.

Limitations/Strengths. The transferability of this study's findings may be limited as they are based on only one focus group consisting of all White women who were highly educated. However, the participants were diverse in age, roles, nursing specialties, and experience. Further, the nurses resided in various geographic areas. The participants also brought strengths to the study. They were attending the Transcultural Nursing Society's annual conference because they were committed to excellent cross-cultural nursing care. Furthermore, their graduate-school education enabled them to articulate their perspectives with depth and breadth. The focus group discussion was robust, producing rich and insightful data. The specific practical assessment and care planning strategies identified in the focus group are a strength of the study, as they may serve as a framework for nurses across clinical settings.

Implications. Numerous implications emerge from the findings. *Clinical nurses* may incorporate the identified CS/PC assessment, care planning and relationship-building strategies into their own practice. They can use the identified attitudes, knowledge and skills as an outline for their own personal assessment and professional development. *Administrators* have opportunities to promote caring and caring relationships as a crucial part of nurses' work and patient outcomes. They may support educational initiatives and policies that honor CS/PC practices and delivery of care models that promote continuity of care. *Educators* may help nurses to cross the theory-into- practice gap by including the participants' CS/PC strategy recommendations into their teaching and evaluation of students' assessment and care planning skills. For instance, they can emphasize and teach caring to nurses by demonstrating, role modeling, and teaching the caring strategies identified in this study. They may use the identified attitudes, knowledge and skills as a basis for their CS/PC curriculum planning.

Researchers may find this study leaves many questions unanswered. Uncovering additional areas of cultural knowledge may lead to effective strategies that advance CS/PC assessment and care planning practices. Investigators may identify additional cultural factors that should be included in nursing assessments. Research may elucidate how nurses show caring in a COVID/post-COVID environment, when caring strategies (e.g. smiles and caring expressions) are masked and handshakes, reassuring touch, and sitting face-to-face with a patient needs to be avoided.

Conclusions

Patients rely on nurses' assessment and care planning skills for their health and well-being. All patients, especially culturally-diverse, minority, or marginalized patients, benefit from culture-sensitive and patient-centered care to achieve high-quality, equitable health outcomes. Although previous research indicated that nurses have difficulty translating cultural theory into their practice, our participants identified multiple concrete, pragmatic strategies that nurses can incorporate into their daily assessment and care planning skills. The study also revealed the attitudes, knowledge and skills associated with CS/PC care and the factors that promote or impede nurses' ability to provide CS/PC assessments and care. Caring emerged as the source for conducting CS/PC assessments and care planning. In addition, our findings provide evidence that CS care and PC care can be merged into a single concept.

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Table 1: Attitudes related to Care of Culturally Diverse Patient

Themes	Attitudes	Participant quotes
Caring	Caring is the core of nursing	*Caring is the essence of nursing. It all comes down to ethics and moral grounding.*
	Cultural sensitivity is inherent to caring	*I feel culturally congruent care is very much a moral obligation of the profession.*
	Caring principles guide practice	*Your heart has to be in it. You have to be one of those warm people who are going to go in there* [to be caring].
	Warm relationship is crucial	*It's really, really important to develop a relationship. And it doesn't go well if you immediately launch into clinical questions. You have to establish a relationship first.*
	Kindness & patience are crucial	*…and just being kind and patient.*
Humility	Openness, non-judgment & acceptance	*I go to them with a completely clean slate. And I just let them know that I'm trying to learn about them and do it their way.*
	Patient's concerns are nurse's concerns	*I frequently just say…What's most important to you right now? Because what I think is important to them isn't really what they're concerned about.*
	Willingness to incorporate patient's culture into care	[I am] *focused on making sure that the information I'm receiving from the patient, is then* [used to plan care] *congruent with their cultural beliefs and practices*.

Patient-as-partner	*I offer collaboration…from the beginning. So, I say 'Let's see if we can work that out together?' Making it a very collaborative effort between me and the patient...*
Willingness to take risks & make mistakes	*You're going to make mistakes and you're going to accidentally offend people even when you don't mean to. And it is OK to make mistakes. It's just part of becoming culturally competent.*

Table 2: Knowledge Transcultural Nurses Consider Helpful for CS/PC Care

Theme	Nurse knowledge	Participant quotes
Self-knowledge	Aware of self as a cultural being	*You need to know where you're coming from in order to care for others…identify* [your own] *biases.* *I truly feel that the* [nurse] *needs to do a self-assessment first, and answer all the questions that they're getting ready to ask the patient…* to *find where they have common ground and where there may be potential conflicts.* *Look at personal biases and our own value system. Prejudices can also impact the way we offer care to people. As long as we do the self-reflection piece,* [we can provide care] *in a culturally sensitive manner.*
Norms of populations served	Cultural knowledge of groups	*You have to know the population that you are caring for…*
	Body language & etiquette	*I watch their body language... Then I try and reflect that because… if you want to give culturally competent care, it has to do with* [non-verbal] *communication.* *Even myself coming from a Middle Eastern background, it's hard for me to know whether they like to do certain things, certain ways for you to shake their hand. Female to a male provider, whether they like that or they don't like that.*
	Differing perceptions of time	*What I have tucked away in the back of my head is, is this patient present day-oriented, past-oriented or future-oriented? And if they are present day, like a lot of my Mexican patients are present-oriented, what we do is something short term, that goes for a week.*

Theme	Nurse knowledge	Participant quotes
	Family dynamics & roles	*I ask them, what does your family think of you should consider to help with your issue? Have you consulted your family? Because usually family is a huge involvement in the decision-making process, especially if living in a household with multi-generations.*
Each patient unique	Multiple factors influence individual's cultural norms	*The challenge is that you are working with a diverse group of individuals…It actually becomes very challenging to be culturally congruent. Not everyone of the same culture has the same practices and beliefs and ideals.* *I just let them know that I'm trying to learn about them and do it their way because not everyone within the Mexican community is the same or in the Arabic community is the same.*
	Patient is own cultural expert	*Even myself coming from a Middle Eastern background, it's hard for me to know whether they like to do certain things, like shaking hands. So, if you don't know, you should ask them, can I shake your hand? It's always important to ask so that you are providing culturally competent care*.
CSC application principles	Framework for CSC assessment & care planning	*The term 'cultural assessment', just that in-and-of itself, allows for the discussion about one's cultural beliefs and values*. *I think that being aware of the need for cultural competence and knowing how to provide it are two very different things*. *And I think that there are a lot of places where they know that it's important, but* [nurses don't know how to do it.]

Table 3: Skill: Relationship-Building

Principle*: A warm caring nurse-patient relationship provides the milieu for CS/PC assessment and care planning*

Theme	Strategies	Participant quotes
Demonstrate respect	Respect for individual	*That's the importance of patient-centered nurses, that you go in with a blank slate or without any bias or assumptions. And you walk in, to see that individual and ask what their needs are, what they would like and what they prefer.*
	Engage respectfully	*I walk in and introduce myself. And then call them by name and say 'Is that how you like to be addressed?'* *I always shake hands, I always sit down, I never stand during an appointment. But I think sitting down as opposed to being a provider that stands there, like you can't wait to get out the door.*
	Be present	*Some nurses* [are] *just 'not there.' No one's listening to them.* *I think it* [attentive listening] *acknowledges they're an individual and not necessarily the next patient in line you have to get through very quickly.* *Communication. You can…walk in and* [do a task] *but if you…don't even look at* [the patient], *you've communicated that* [you don't care] *about them. So, I usually lean in, I'm listening to them, nodding… communicate caring, warmth, openness, relationship, empathy.*
	Communicate caringly	*It's really about communicating… Communicating warmth…caring… relationship…openness… empathy.*
	Partner with patient in equitable relationship	*Whenever patients share with me their concerns, I offer collaboration with them from the beginning. So, I say, 'Let's see how we can work*

Theme	Strategies	Participant quotes
		that out together' or 'Let's see if we can solve that problem,' or 'Let's see how we are going to address this.' Making it a very collaborative effort between, me and the patient. We're going to work together…
Demonstrate caring	Listen to patient's concerns	*What we think is important isn't necessarily what they think is important. So just really listening.*
	Acknowledge patient's emotional & physical state	*When you can see that they're really…upset or you could hear that they're congested. I make an observation…"It seems this is a really tense time for you…You sound really congested. Is that a concern for you?"*
	Convey human connection using selective personal disclosure & sharing	*I give them personal information, if it's appropriate. If I've experienced* [the concern] *or seen it in my family…whatever it is, I just try to give a little piece of myself to them.* [If patient is reluctant to follow advice, I say] *"If you were my brother…"- and they might be a big black African man…*[then he thinks] *she kind of thinks of me as her brother.*
	Build trust over time	*I think it takes multiple visits to understand a patient's culture. You don't always have that* [trust immediately] *but the point is, do not assume you're going to have it on that first visit. You're going to get it after a couple of other visits.* *Sometimes, they need another appointment to establish trust.* *Do* [nurses] *get to know their clients? Is there a continuity of care? Do they go to the same people each time? Because you really need a relationship.*
Be flexible, honoring patient's culture	Use phrases from patient's primary language	*If I know* [some words] *in their language I'll use them…. And if I don't know, I ask them. "How do you say* [Hello, thank you] *… you're welcome?...*

Theme	Strategies	Participant quotes
		goodbye?" They know you care when you do that.
		I don't speak Spanish, but I speak a little bit. I know how to say "I'm a nurse practitioner." The fact that you just talked to them a little in their language means a lot. They start smiling…Even when you say it wrong, they laugh and you laugh with them.
	Adopt patients' body language and follow their etiquette norms	*If you want to give culturally competent care and it has to do with communication, you watch their* [body] *language and then you mirror that... So if there's little eye contact, you do little eye contact, if they lean, you lean in, that kind of thing.*
		[If appropriate] *I take my shoes off when I enter the home.*
		So if you don't know, you should ask, can I shake your hand?
	Show acceptance of patient's spirituality/religion	[Ask about] *their spirituality or their religiosity… acknowledging* [this as part] *of their decision-making process, and that you are supportive of that.*
	Personalize plan of care	*I think culturally congruent care…should be patient-focused, individualized to what their needs and cultural needs are.*

Table 4: Skill - Assessment

***Principle**: Assess to discover and appreciate patients as unique, cultural, valued persons.*

Themes	Strategies	Participant quotes
Patient-centered focus	Be patient-centered	*I think culturally congruent or sensitive care…should be patient focused. So individualized, understanding what their needs are and what their cultural needs are.* *Person-centered is a holistic overview of psychosocial needs, social determinants of health, religious, cultural practices around health and wellbeing.*
	Discover the person inside the patient	*Go in with a blank slate, without any bias or assumptions. Ask what their needs are, what they would like, what they prefer.* [Ask questions like] *What's most important to you right now? What do you think is going on? How would you treat this? What can I do?*
	Acknowledge/inquire about patient's present emotional or physical state	*Recognize, acknowledge something that they seem to be experiencing or alluding to. You can see it in their eyes, and in their face and in their body language…the physical and the emotional…giving them the opportunity to talk…* [It helps] *a little bit with the interpersonal relationship. I think it acknowledges they're an individual and not necessarily the next patient in line that you're seeing and you have to get through very quickly.*
	Provide a holistic assessment	*Person-centered care is a holistic overview of psychosocial needs, social determinants of health, religious, cultural practices around health and wellbeing.*
Culture-sensitive focus	Ask about patient's cultural beliefs and values	*Do you mind telling me about your ethnicity*? [cultural values, or beliefs] …*because it really helps me understand, so I can help you better.*

Themes	Strategies	Participant quotes
		[Ask] *Are there any spiritual or cultural practices that are important to you, that I need to know about or dietary restrictions?...and things like this* [Ask] *What are they doing …to help* [treat] *their issue?*
	Assess spirituality/religion	*I noticed you have a cross around your neck. How does religion help you during times of illness or disability?*
	Conduct an effective dietary recall	*I always ask what they had for breakfast… for lunch. So, I know where to make some recommendations….* *For a long time, I would ask 'Do you add salt?' And everybody would say 'No' and their blood pressures were high. What happens is they use fish sauce or bouillon cubes… So, now I ask differently 'What seasonings do you use?'*
	Ask about cultural 'special' days	[Ask about] c*ultural practices in different times of the year… Ramadan or different holidays or events.*
	Observe and ask about family dynamics and support	*I ask them 'What does your family think you should consider? Have you consulted your family?' Because, usually family is a huge involvement in the decision-making process. They might want you to speak to the eldest male or female.*
	Investigate health literacy	*Ask what their job was in another country. Then, I know about their education because if they don't have any* [formal] *education, I have to tailor all my teaching to that.*
	Ask before touching or physical assessment	*With clothing and different cultural groups, I will ask 'Are you comfortable showing me the area?'*

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Table 5: Skill - Care-Planning

Principle*: Plan care with patients to enhance patients' health, well-being and lives.*

Themes	Strategies	Participant quotes
Share power	Include family in the process	*You may need to include their family in care* [planning]. *So, when I home-visited mothers and their babies, it was always the mother-in-law that was a primary caregiver. And I had to focus … my interventions with the mother-in-law.*
	Collaborate/share power with patient	*Whenever patients share with me their concerns, I offer collaboration with them* from the beginning…*'Let's see if we can solve that problem'… we're going to work together, 'How can I help you?'*
Build trust	Relationship-building as a process	*They need another appointment to establish trust. And that first visit is not enough…It* [takes] *multiple visits to understand…*
	Respectful of differences; incorporating them into care plan	[I am] *focused on making sure that the information I'm receiving from the patient, is then congruent with their cultural beliefs and practices., is then* [used to plan care] *congruent with their cultural beliefs and practices*.
Apply theoretical models	Prochaska's Readiness for Change Model	*I think it's almost like smoking, when you're asking them, are they ready? You ask them. I think that's the best way to go is to just ask them, where are you in the process? Are you ready to get onboard to try and change your health to do this? …Just ask them, where are you in the process? Are you ready to get onboard to try and change your health? We could do something else until you're ready.*
	Rollnick et al.'s Action Plans	*Find out where they are and what mini-steps can you start with.* *What we do is something short term… 'We're just going to do it for a week and then let's talk*

	about that. We'll get to everything else, but let's just start here.'
Leininger's Modes of Care	*I very much use the 'helpful, neutral, harmful' structure. The helpful things you strengthen and then the harmful things you repattern. So, I try to pick out, for each patient, at least one thing* [helpful] *or neutral thing* [to include in pt's care plan]. [To restructure harmful processes, I say] 'L*et's try to modify it. How does that work for you? And let's just try it out."*

Table 6: Facilitators and Barriers of CS/PC Care

Factor	Description	Participant Quotes
Facilitators	Reflection on self as a cultural being with assumptions & biases	*Prejudices can also impact the way we offer care to people. We* [need to] *do the self-reflection piece.* *The more nurses are exposed to different cultures, they learn to self-reflect and to keep their biases in check.*
	Cultural competency requires formal education	*My nursing goes back a really long time ago before cultural competency was actually taught. And how many nurses need continuing education and practical education?* …[CCC is] *so much more involved than what I think a lot of people understand it to be.*
	Multiple encounters with different cultures	*If you work regularly with people that are* [of different cultures], *for a lot of nurses it's easier to be culturally sensitive and aware.* *I find that the more nurses are exposed to different cultures, they learn to self-reflect and to keep their biases in check.*
	Organizational values & priorities	*It depends on the philosophy and the mission statement where you're working, and if* [CCC] *is a priority.*
	Models of care delivery support relationship building	*Is there a continuity of care? Because … you really need a relationship, it is important.* *You have to have time to really ask 'Are any spiritual or cultural practices that are important to you, that I need to know about?' I agree that in 15-minute appointments, it's pretty challenging to ask things unless it's directly relevant to my care.* *I think that once nurses find out that if they put a little bit of effort into being culturally sensitive, it makes their job easier and the patient has better outcomes.*

	Evolving attitudes	*I like to think that* [cultural competence] *is coming out more and we're being more aware and sensitive… I think it's getting better, but I think we have a ways to go yet.*
Barriers	Caring is perceived as not modifiable	*You can't make people care. You can teach them, but if it's not in them.*
	Insurance/organization restrictions	[Schedule] *additional appointments if the service mandate is not restrictive of you … seeing that person again*.

CHAPTER FIVE – MANUSCRIPT 2

This chapter addresses the process by which home health nurses conduct culture-sensitive/patient-centered assessments and care planning I used the data collected from the home health nurses to discover what the nurses think about culture-sensitive/patient-centered care, how they learned about it, and how they incorporate it into their daily care of patients. Gradually a theoretical model emerged from the data. A striking characteristic of this process is how unstructured this process is because nurses did not learn it through education but through their personal experiences. Experiential learning is a trial-and-error process, as one nurse described, 'learning by the seat of your pants.' This is not an efficient process, and it does not always result in result in an effective process, that is, best patient outcomes.

In this model, the attitude and virtue of caring emerged as the primary source and destination for culture-sensitive/patient-centered care. As caring nurses interact with culturally diverse, minority and stigmatized patient populations, they are driven to know their patients as persons and to help them achieve health, well-being, and the lives their patients want to live. These two objectives help nurses discover strategies that can be described as culture-sensitive and patient-centered.

Some nurses take another step towards assessment and care-planning skill development by reflecting on the effectiveness of their care with critical and creative thinking. They ask themselves if their assessment and care-planning processes are working for their diverse patients and they ask themselves what might work better.

Gradually, they refine their assessment and care-planning practices so they are increasingly culture-sensitive and patient-centered. Unfortunately, most nurses felt that they were impeded in their ability to use their culture-sensitive/patient-centered skills by agency and Medicare efficiency, cost-cutting and documentation policies that decreased the actual time the nurses had to incorporate culture-sensitive/patient-centered care strategies into their practice. Some nurses were overwhelmed, frustrated and 'burnt out' because of these impediments. Some nurses, however, respond to the adversity of these barriers with resilience, maintaining a 'can do' attitude and a willingness to experiment with new strategies to balance patient needs with agency and Medicare needs.

A Grounded Theory Study of Home Health Nurses' Journey towards Culture-Sensitive/Patient-Centered Skills [Manuscript 2]

A Grounded Theory Study of

Home Health Nurses' Journey towards Culture-Sensitive/Patient-Centered Skills

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Abstract

Background: Home health patients, who are members of minority and vulnerable groups, suffer disparate outcomes. Patient-centered care (PCC) and culturally-competent care (CCC) aim to facilitate high-quality, equitable care. No research about how home health nurses incorporate PCC and CCC principles into their assessment and care-planning practices currently exists.

Purpose: The study explores the answer to the question, "*What is the process by which home health nurses develop their culture-sensitive/patient-centered assessment and care planning skills?"*

Methods: We used a grounded theory design and recruited home health nurses (n=20) into the study. We conducted in-depth recorded interviews using a semi-structured interview guide to ask questions about nurses' assessment and care-planning practices, their understanding of CCC and PCC principles, and facilitators/barriers to CCC and PCC practice.

Results: Participants primarily gained their CCC and PCC assessment and care-planning skills through a 'seat of your pants,' trial-and-error process, with little educational or agency assistance. They combined caring, diverse patient experiences, and critical, creative self-reflection on their experiences to gradually learn effective CCC and PCC strategies. However, they reported many barriers that discouraged or distressed them in their quest to deliver culturally-competent and patient-centered care. Only some nurses were able to muster the resilience to overcome these challenges creatively and happily.

Conclusion: If we accept that patient-centered care and culturally competent care are key elements of high-quality, equitable care, the grounded theory process uncovered may help

home healthcare clinicians, administrators, educators and policy-makers identify impact points for enhancing CS/PC practices.

Key words: nursing assessment, patient assessment, nursing care planning, patient care planning, culturally competent care, patient-centered care, home nursing professional, home health nursing, healthcare disparities

Grounded Theory Study of

Home Health Nurses' Journey towards Culture-Sensitive/Patient-Centered Skills

Introduction

Home healthcare patients are at risk of outcome disparities when they are members of minority, marginalized or vulnerable patient populations.[1–10] In the United States, disparities among these high-risk populations have been repeatedly documented across multiple settings.[11] Disparities are also documented in home health care.[12–14] Disparities can indicate that regulatory, accreditation, and professional standards for high-quality, equitable care are not being met.[4] In addition, disparities cost billions of dollars to the healthcare system and society every year.[15] Disparities are indicators of poor-quality, unequitable care.

The problem of *poor-quality care* was addressed in the Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, which proposed that *patient-centered care* (PCC) was an important element of high quality care.[16] The problem of *inequitable care* was also addressed by the IOM in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* which ignited the *culturally-competent care* (CCC) initiatives.[17] In response to these IOM recommendations, various organizations have incorporated PCC and CCC principles into their practice standards and guidelines to improve the quality of care, patient satisfaction and/or patient outcomes.[18–23] PCC and CCC are now the standard of care.

A search of the research literature identified a limited number of studies that addressed the concept of culturally competent care in home health nursing.[24–26] Similarly, only a few studies (with small sample sizes) conducted outside of the United States addressed patient-centered care in home health nursing.[27–30] None of these studies addressed how home health

nurses (HHNs) developed these skills, and fewer reported barriers nurses encountered when trying to provide CCC or PCC.[24,25] Our search of the literature located no studies describing how HHNs incorporated patient-centered or culturally sensitive care into their assessment and care planning practices.

The concept of PCC has been defined as "providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[16(p3)] The same definition can be used to define CCC, though another definition describes it as care that is "respectful of and responsive to the health beliefs, practices and needs of diverse patients."[31] Notably, CCC is not just for patients from diverse racial or ethnic populations. Because all patients are members of multiple cultures (age, sexual orientation, gender identity, religious, socioeconomic, lingual, geographic, occupational and other ways that groups differ from the normative group), each person is a unique cultural being who benefits from culture-sensitive care.

In concept analyses, researchers have defined characteristics of PCC[32,33] and CCC[34,35] in nursing. These analyses indicate both concepts share two defining characteristics. First, clinicians respectfully listen to and care about their patients' values, goals, needs and preferences, and second, clinicians partner with their patients to develop care plans that enable patients to feel "well cared for." In addition, some researchers, noting that PCC and CCC have very similar principles and use very similar strategies, recommend thinking of them as a merged concept.[36,37] Indeed, care cannot be patient-centered unless it is culture-sensitive, and it can't be culture-sensitive unless it is patient-centered.

Consistent with the above research, we propose that CCC and PCC be merged into one concept, with one other consideration: several scholars have criticized the term "culturally

competent care" as being arrogant, lacking nurse humility within the nurse-patient relationship.[38–40] Moreover, the term "competency" focuses on the nurse instead of the patient, rendering the term *not* patient-centered. So, a term like "culture-sensitive care" (CSC) is more appropriate. For the remainder of this paper, we use the term "culture-sensitive/patient-centered" (CS/PC) care to identify the concept that helps achieve high-quality, equitable care for diverse patient populations.

Purpose of study. In their landmark paper – *The Future of Home Health Care* – Landers and colleagues state that one of the "pillars" of home health care should be "patient/person-centered care, which assures that patients' preferences, needs and values guide patients' plans of care."[41(p272)] But Landers and colleagues posed the question: "What constitutes person-centered home health care and how [is it] defined and measured in home healthcare?"[41(p272)] This study explores the answer to this question, using the merged concept of CS/PC care and narrowing the focus to nurses' assessment and care planning skills. The research question is: *What is the process by which home health nurses develop their culture-sensitive/patient-centered assessment and care planning skills?*

Theoretical Perspective. Grounded theory research asks researchers to approach data with a "blank-slate mind," eliminating the assumptions found in theoretical frameworks, in order to better "hear" what the data is saying. Yet it demands researchers describe their experiences and philosophical worldviews, since these undoubtedly influence their interpretation of the data, even though they work hard to "bracket" their default assumptions. The first author – a doctoral student, Home Health Clinical Nurse Specialist and Certified Transcultural Nurse – grounds her nursing philosophy in caring science and transcultural nursing theory, especially as articulated in Ray's *Transcultural Caring Dynamics Model*.[42] The second

author, an Associate Professor of nursing and a qualitative researcher with a critical, emancipatory worldview, guided and reviewed all stages of the study.

Methods

Design

This paper describes the second component of a mixed-method study. In this component, we employed a grounded theory approach, guided by the recommendations of Corbin and Strauss.[43] We conducted in-depth, individual interviews with HHNs about how they incorporated CS/PC principles into their assessment and care planning practices; we inquired about how they developed these skills. We incorporated strategies to enhance the trustworthiness of the study findings. Confirmability is supported by assumption bracketing, prolonged engagement with data, constant comparison analysis, and rich descriptions of the data. Credibility and dependability were promoted with journaling, memoing, and peer review of the coding and analysis process. Transferability is enhanced by maximal variation of the sample and disclosing researchers' underlying nursing philosophies.

Sample

Eligibility. The study focused on the population of American professional (registered nurse) home health nurses (HHNs: nurses who provide care to patients in their homes). Eligible HHN participants 1) provided intermittent skilled care, 2) assessed and planned care for diverse patients, and 3) had at least one year of home healthcare experience. As the study progressed, eligibility criteria were expanded to HHNs actively involved in supervising or educating HHNs to achieve maximal variation and support theoretical sampling.

Sample Recruitment. Participants were purposively recruited via flyers posted on various professional and home health agency websites. Additionally, some participants were

recruited through snowball sampling strategies. If interested, potential participants contacted the researcher via e-mail and, after explaining the study, an in-person or virtual interview was scheduled. Recruitment continued until the data became saturated (new interviews were not providing additional relevant theoretical data).

Data collection

The interviews were conducted by the first author between January and June 2020. Face-to-face interviews were conducted in a location that provided privacy; virtual online interviews used a secure audio/visual platform. We transitioned to only virtual interviews in March 2020 in response to the advent of the COVID-19 pandemic. The interviews lasted between 50-75 minutes and they were recorded. Any visual recording from virtual interviews was deleted, leaving only the audio portion to protect participant confidentiality. Personal identifying details were removed before verbatim transcription and transcripts were imported into Dedoose,[44] a web-based application for managing and analyzing qualitative data.

We used an interview guide for the semi-structured interviews, consisting of open-ended questions about the participants' and their colleagues' practices and experiences. We asked about nurses' assessment and care planning practices, their understanding of CSC and PCC principles, and practices they use to achieve CS/PC care. We also encouraged participants to discuss facilitators and barriers to providing CS/PC care. The interview guide evolved to more deeply explore initial themes mentioned in the interviews, such as perspectives on disparities, non-adherent patients, language barriers, and impact of Medicare/OASIS on their care practices.

Analysis

Consistent with grounded theory procedures, the first author began fragmenting the data from the first interview with open coding. Subsequently, each interview was coded and

compared to the data in previous interviews in an iterative process. As the study matured, we categorized data into axial codes. During the selective coding process, four themes emerged relating the axial categories to each other. As the analysis matured, we compared the attitudes, knowledge, and skills of the CS/PC experts from the first component of this mixed-method study (authors, in review) to each participants' CS and PC narratives to enrich the understanding of HHNs' skill development along a continuum.

Ethical Considerations

The study was approved by the George Mason University's Office of Research Integrity and Assurance (GMU IRBNet Number: 1450243-1). All participants signed a written informed consent prior to participation. In presenting the participants' quotes, edits were made to shorten the quotes and render them grammatically easier to read, while maintaining the integrity and meaning of the quote.

Results

Sample Demographics

Most of the participants (n=20) were White females (1 Black, 1 male). These nurses were recruited from 11 states in the Northeast, Southeast, Midwest, Southwest and Western regions of the country. Most nurses were employed by for-profit agencies; six worked for not-for-profits. Their average age was 52.5 years (range: 25 to 68 years). The nurses averaged 13 years (range: 1 to 45 years) of home health nursing experience. Four nurses had ADN degrees, 11 had a BSN, and 5 had an MSN or allied health master's degree; nine participants were certified in diverse nursing specialties. Most of the nurses in the sample worked as case-managing clinicians, though some had supervisory, educational, or quality assurance roles on a part-time or full-time basis. In their personal lives, five participants relayed significant

experiences with people of diverse races/cultures (i.e., parents or spouses) or extensive experience working in another country or with a distinctive cultural group.

CS/PC Skill Development as a Journey

The participants' learned their CS/PC skills experientially. They reported gradually progressing towards CS/PC skills through a trial-and-error process. One nurse described the assessment and care planning journey as "nursing by the seat of your pants." Another nurse explained, "Anything I learned, I learned the hard way. I learned through experience." Experiential learning, without a guide, can be a slow and difficult journey, characterized by random learning opportunities and hit-or miss learning. As a result, some participants developed effective CS/PC skills; others were less successful. The nurses on this journey were situated along a continuum of CS/PC assessment and care planning skills. As the participants described their CS/PC journey, four themes emerged: 1) *Embarking on an uncharted journey, 2) Lacking a compass or road signs, 3) Encountering potholes and roadblocks,* and *4) Side-stepping and transcending barriers.*

Theme 1: Embarking on an uncharted journey

Caring. Participants tended to be propelled along their journey toward CS/PC assessment and care planning skills by the foundational, driving concept of caring. Because they truly cared about patients, participants tended to care about what their patients cared about, which stimulated their desire to know their patients in holistic ways. Knowing the patient as a person, they tended to adapt their care so patients could achieve their aspirations while having their values and preferences respected. Because they cared, participants tended to focus on seeing the patient's problems from the patient's perspective, instead of merely from a medical or Medicare perspective.

Most participants emphasized *being caring* as their approach to the patient. Characteristic comments included “You meet your patient, you love on them, and you give them what they need” and “I'm giving to them from the heart and I'm treating them like my mother, my father.” C*aring values* helped nurses to be truly centered on patients. One nurse said, “You have to be a people-person and you have to come to patients from a curious perspective, not a judgmental one.” Similarly, another nurse said, “You treat them with kindness, empathy, compassion, understanding.” These values supported a non-judgmental attitude that inspired cultural humility.

The participants emphasized the importance of forming a *caring relationship.* “I think the relationship is absolutely the most important thing… the patient trusts you, you will be able to accomplish so much more” one nurse explained. She described how patients reveal themselves in their story: “I build trust by really listening to what they're trying to tell me because that unravels so many things about why they are, or are not, doing something” Other participants echoed by saying “I meet them where they are…tailor what I'm doing… the type of language you use…you've got to build that rapport with them first.”

Experiences. Participants described seeing their life experiences and professional encounters with patients of diverse cultural, minority and stigmatized groups through a caring lens. Caring inspired them to be person-centered when interacting with a person of a culture different from their own. For some nurses, *life* experiences engendered openness. One nurse described her multi-cultural upbringing: “I grew up an Army brat and my mom's German. And a lot of my mom's friends are Asian. I was exposed to a lot of cultures that other children weren't. I think that's helped me with my cultural competency.” Another participant explained that “Some nurses don't understand how culture [influences health care]. They don't get it because

they have not experienced it [in their lives]. It's different for me, because my dad was Muslim, and my mom is Christian. So, I was raised two different ways. For people who have had a 'one-street life,' that is all they know. It's hard to understand other cultures when you only lived one way." These nurses believed that adapting to the customs of different cultural groups is part of the human experience.

The participants also described how their *professional experiences* with patients from different cultures shaped their skillset. For instance, nurses described how serving on an inpatient HIV unit or medical mission work helped them become increasingly aware of an individual's unique culture, preferences, and needs. An assertion by one nurse was echoed by other participants: "[I learned] to be culturally sensitive by being a homecare nurse. You see so many different people that you just roll with it. You get used to it. You take it in." By processing their encounters with diverse patients, through a lens of caring and related values, nurses progressed in their journey towards becoming a CS/PC nurse.

Creative/critical reflection. Several participants described reflecting on their assessment and care planning experiences, critically and creatively thinking about their 'seat-of-their-pants' experiences with patients. One nurse said, "I have probably psychoanalyzed a lot of the experiences that I've been through to learn from my mistakes." Another participant said, "I have had experiences with people of different cultures, and I am able to look back on them, to think… What could have been done differently?" Another nurse said, "[You have] to look at yourself and remove your barriers. Look at what you do and look at how you could do it differently." One participant reflected on her mistakes and readjusted her approach; she admitted "I made an assumption and found out I was wrong. I needed to step back and not be pushy, instead to be curious, to understand a little bit more about their culture." Combining

self-reflection, critical thinking and creative thinking enabled these nurses to humbly think about what worked and what didn't. When they combined these observations with creative thinking, they thought of new strategies that might work better.

Theme 2: Lacking a Map or a Compass

Most participants felt they were inadequately prepared to provide CS/PC care, as though they were sent off on their CS/PC journey without a map or compass. Several nurses felt their inefficient trial-and-error approach could have been avoided if they had received better education and agency support in delivering CS/PC care. For instance, one nurse said "I don't think most nurses are xenophobic of other cultures; they're just uncomfortable with what they don't know. And that makes them want to spend less time out of their comfort zone and so the patients get minimum visits."

Education. Nursing education provides a framework for practice; it serves as a map for the nursing journey. However, several nurses seemed to have no knowledge of what CS/PC care is or how to integrate it into their practice. For instance, one nurse conceded "I don't know that I've heard about PCC." Similarly, another participant admitted, "I've never heard of culturally competent care before." While it may not be crucial that nurses know terms such as CCC or PCC, it is important they know how to deliver CS/PC care. Yet one nurse unaware of CS/PC principles said she never asks question about culture or religion because "[What is the point?] You're going to treat them the same no matter what." Again, violating CS/PC principles, one nurse described an authoritarian approach to care. She said "I let the patient know that I'm in charge. You let them know that you're the boss, that you know what you're doing, and your job is to teach them and help them make changes in their lives."

Most participants felt that their basic education in *nursing school* did not prepare them for CS/PC care. One nurse reflected on how inadequate her training was for a multicultural patient population. “I remember being in nursing school and we had a very, very, very short module about cultural diversity and it did not do what it should have done. It was so small, but we live in a world where the cultural diversity is so large.” Worse yet, one nurse decried the cultural *in*competence of the cultural education she received, revealing how inappropriate teaching can derail the CS/PC journey. “We had one class on cultural diversity… the way that it was taught was very prejudiced…essentially learning stereotypes.” The participants felt they were not trained to conduct assessments and care planning, in CS/PC ways.

Many participants believed that home health agencies have an important role in helping HHNs develop their CS/PC skills. Noting that HHNs are guests in patients’ homes, participants felt they need more advanced and specialized CS/PC skills than are needed in acute care and facility-based settings. However, HHNs have little opportunity to learn these CS/PC skills due to the autonomy of their practice. As one nurse commented, “I think that as a home health nurse - working independently - it is hard to develop [home health CS/PC] skills. We need good mentors.” Nurses also suggested that orientation sessions about CS/PC in home care would be helpful; further, preceptorships, case conferences, and other peer learning opportunities would help them hone their CS/PC skills.

Agency Support for CS/PC care. Participants commented that another “compass or road sign’ that steers nurses towards CS/PC skills are agencies that promote a CS/PC culture, which in turn facilitates CS/PC assessments and care planning. One nurse commented on how her agency’s mission statement highlighted patient-centered care for diverse patient populations. . “I feel as though the mission statement really resonates with nurses. Before you do anything,

you should be following our mission, our values." Participants also commented that agencies who value quality of care rather than quantity of care (patient-centeredness vs. as many visits as possible) should institute policies and procedures that give nurses time to build nurse-patient relationships and assess and plan care in CS/PC ways.

Theme 3: Encountering Potholes and Roadblocks

Most participants bemoaned the daily barriers and negative pressures that made it difficult to provide CS/PC care to their patients. Among these potholes and roadblocks were a lack of time to deliver CS/PC care due to productivity and compensation policies, documentation systems and requirements, and new business models changing the way care is delivered.

Lack of time. Most participants described how a lack of time impeded their ability to practice CS/PC care. As one nurse complained, "I think in home care today, everybody is overworked, overwhelmed. One cannot work like that and give proper care. I hear continuously, 'Too many patients, not enough time.'" Another nurse insinuated that a lack of time compromised patient outcomes. "Time is one of the biggest barriers because if I had more time with these individuals, I could make more progress." Another nurse said that in the culturally diverse area in which she worked, the nurses were culturally aware, but they lacked the time to translate their awareness into culture-sensitive practices, which take time.

Productivity and compensation. Participants tended to believe that productivity requirements were inconsistent with CS/PC assessment and care planning practices and that they were unrealistic if agencies wished to support CS/PC care. One nurse said, **"**The focus is on productivity. The focus is on 'get as many patients seen as possible.' It pushes people to go faster and that makes it harder to give patient-centered care, because you're rush rush rush rush rush. You're like, 'I've got to get into this one, then I've got to go see this one.'Boom boom

boom boom boom." Participants also complained about the pay-per-visit compensation system, which they felt incentives seeing as many patients as possible at the expense of quality care. For instance, one nurse felt that her colleagues focused on getting in-and-out as quickly as possible. Another nurse said, "The thing is time is money. The more time I spend with one patient, the less likely I can go see another one."

Documentation systems and requirements. Participants frequently felt that their EMR systems discouraged CS/PC assessment and care planning by making it difficult to capture the individuality of the patient and their needs on the assessment and care planning forms. "They are so cookie cutter that they don't say anything about the individual patient." Several participants commented on the lack of cues for important CS/PC elements of a patient's assessment. Participants also tended to feel documentation time robbed them of time they should be spending helping patients. One nurse, commenting on the time she spent documenting care, said "It's incredibly burdensome and the time that it takes to chart overwhelms the time that you have with the patient." Participants tended to resent how much of their documentation was repetitious and irrelevant to the patients' needs. They complained that they couldn't focus on the patient's priorities because they spent so much time on meeting Medicare criteria.

Business orientation to patient care. Many participants felt that their agencies were making business decisions that were compromising the quality of care they could provide. As one participant said, "The business model they impose on us doesn't jive with patient-centered care." These participants felt that agencies were using a business management approach instead of a patient-centered model of care. For instance, one case-manager said that the care of each patient in his agency was divided between an admissions nurse, case manager, per diem

nurses, and LPNs, so that he didn't know the patients he was managing. Others complained about 'algorithmic scheduling,' strict supply budgets, inadequate social workers and other complementary services needed for good outcomes.

The potholes and roadblocks affected participants in different ways. Some participants felt the barriers were insurmountable and felt deeply discouraged and guilty, experiencing moral distress and burnout. Some of these nurses were thinking about leaving home health nursing. Others stayed in home care but seemed to disengage from CS/PC care by succumbing to a task-oriented, instead of a patient-centered, approach to care. Some participants navigated the potholes and road blocks more successfully but struggled to maintain a balance between a CS/PC approach to the patient with their responsibilities to their agencies and Medicare. Some of these nurses expressed that their tasks often extended beyond their full-time hours, leaving them without work-life balance. And yet, other nurses maintained a caring, committed, CS/PC attitude, stating they loved being a home health nurse.

Theme 4: Side-stepping and Transcending Barriers with Resilience

The participants who maintained their commitment to CS/PC care had found constructive ways to practice, despite the demanding home health care environment. These nurses perceived barriers as challenges. They found ways to side-step or transcend the barriers with a resilient attitude.

Side-stepping. Several participants solved the time-productivity problem by moving to positions that exempted them from productivity requirements, such as preceptor or education positions, where they could promote CS/PC care. Other nurses happily 'donated time' so they could give the CS/PC care they wanted to deliver. They change to part-time status, with part-time productivity, while working full-time hours or they accepted that they needed to work

extended hours to meet the 8-hour days' productivity expectations. As one nurse explained, "I'm going to give the extra time. First, because I think every person deserves to have that; but second, because I have the flexibility to do that."

Transcending barriers. Several participants felt, although there were barriers, they were 'up to the challenge.' They confronted barriers with a 'can-do' attitude, a sense of confidence, positivity, optimism and resilience that enabled them to believe they could be more creative or innovative, enabling them to change or transcend barriers. A participant who exemplified this attitude said, "I make it work for me and for the patient. And I can make it work for the agency as well. I'm not afraid to think out of the box, change the way I do things. I am always thinking is there something that I could do differently to be more successful?" The participants who were able to side-step or transcend the barriers home health nurses confront travelled the furthest in acquiring CS/PC assessment and care planning skills.

Grounded Theory: "Nursing by the Seat of Your Pants"

In analyzing the four themes, a process of how these home health nurses developed their CS/PC assessment and care planning skills emerged from the interview data. The development of these skills was like an uphill journey (as signified by the large arrow) from vestigial towards excellent skills. Although facilitators (education and agency support) could have 'pulled' their skills 'forward and higher' more quickly, the nurses slowly learned these skills on their own.

In general, the nurses came to home health nursing with a commitment to caring that honors patients as unique valued persons. As they had experiences with patients of diverse cultural, minority, and stigmatized groups, their caring inspired a commitment to patients' health and well-being. Thus, the patient became the center of their care (patient-centeredness)

and the patient was recognized and cared about as a cultural being (cultural sensitivity). However, for these nurses learning CS/PC skills was an experiential process, frequently without education in the principles and processes of CS/PC care. It was a random and incomplete learning process – 'nursing by the seat of your pants.'

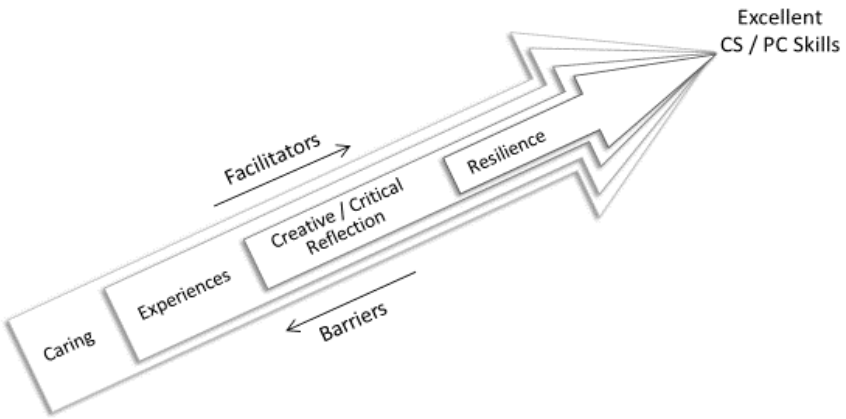

Figure 2: Home Health Nurses' Journey to Culture-Sensitive/Patient-Centered Assessment & Care Planning Skills

Some nurses took their CS/PC learning to the next level through reflection on the strategies they use and the effectiveness of those strategies. Using creative/critical self-reflection, they gradually enhanced their CS/PC assessment and caring planning skills. Yet, the home health nurses encountered many agency and Medicare policies and processes (productivity requirements, documentation burden, etc.) that they perceived as barriers to CS/PC practice. These barriers tended to 'pull and push' them downward in their climb to incorporate CS/PC assessment and care planning into their practice. Some nurses responded to the barriers by succumbing to a task-oriented (as opposed to a CS/PC) approach to care.

However, several nurses responded to barriers with resilience, which enabled them to use their creative/critical-thinking skills to navigate around the barriers to further enhance their CS/PC assessment and care planning skills.

Discussion

Caring drives CS/PC care. Caring is an essential concept in nursing.[45,46] Caring was the main underlying motivation of the HHNs in this study. Caring drove patient-centered care, inspiring the nurses to *want* to develop trusting caring relationships with their patients. These relationships helped the participants learn about the patient from the patient and helped them provide care that was consistent with the patient's aspirations, values, and preferences. These caring desires are embodied in the three elements of patient-centered care: 1) build a warm, trusting, caring relationship with the patient; 2) assess to understand the patient as a person; and 3) plan care with the patient to meet their aspirations and values (authors, in review). The same elements also define culture-sensitive care. Caring nurses learn from their experiences with their diverse patients that being patient-centered means being sensitive to the cultural perspectives that shape the patients' perspective and decisions about health care related issues.

Caring and its CS/PC care practices are particularly important in home health nursing. Home health nursing is a specialized area of nursing practice; providing nursing care in patients' homes requires unique nursing skills, one of which is advanced assessment and care planning skills.[47] As HHNs are 'guests in patients' homes, nurses need to develop a caring relationship with the patient to engender trust and support adherence. Practicing CS/PC principles is key to enabling home health patients to reach their optimal outcomes. Most nurses in the study were attracted to home health nursing as they perceived it to be the ideal setting for exercising their caring values and principles.

Education. Although all nurses in the sample demonstrated some CS/PC attitudes, knowledge, and skills identified by transcultural nursing experts (authors, in review), they tended to attain these attributes gradually by 'experimenting' on their patients. It is possible that "nursing by the seat of your pants" could contribute to poorer outcomes. In addition, the nurses' CS/PC skills were on a continuum and all nurses in the study had some knowledge deficits about what CS/PC is and how to best deliver it. Most nurses in this sample indicated that they had never formally learned about the relationship of culture to health, health care, or health decision-making as emphasized by nursing theorists.[20,42,45,48,49]

Acute care nurses learn how to be "good nurses" through peer sharing and mentorship in the course of patient care. Hence, the novice nurse in a specialty area may learn from experts serendipitously or through direct demonstration during daily patient care. Supportive teams, formal mentors, and role models may promote competence and inspire excellent practices. Alternatively, the autonomy of home health nursing precludes this kind of on-the-job learning. In general, nurses new to home health care tend to learn CS/PC strategies on their own. This haphazard fashion of acquiring skills may result in different degrees of success. Home health agencies can support preceptorships during orientation, case conferences, and other types of peer-learning activities that promote a transfer of knowledge from seasoned nurses to the novices.

Business of home health care. Many nurses in this study believed that an emphasis on cost efficiencies impeded CS/PC care delivery. They felt that the new business model of home care was supplanting the traditional, holistic, patient-centered nursing model. Although care "at the least cost" may be desirable, it may undermine the quality of care if applied aggressively. For instance, Koch followed a patient's journey through a hospital's outpatient, surgical, and home

care services, tracking the impact of cost-cutting, efficiency measures and policies on the patient's clinical care. Ultimately, she concluded that these processes contributed to the patient's unnecessary death.[50]

Kennedy reported that corporate take-overs of community healthcare systems could be "squeezing the humanity out of health care."[51(p7)] Discussing high patients/nurse staffing ratios, Kennedy suggested that when nurses are hard-pressed to provide care and teach patients what they need to know, nurses suffer stress and burnout. High patients/nurse ratios are to are to facility-based nursing as high- productivity levels are to home health nurses. The participants' perceptions that high productivity compromises the quality of care are supported by previous research. Aiken and other nursing researchers have found that increasing nurses' workload with increased patients/nurse ratios, has a negative impact on patient outcomes and increase nurse burnout both in hospitals and home care.[52–56]

Limitations. This study was conducted at the same time the Patient-Driven Groupings Model (PDGM) payment system and COVID pandemic hit home health agencies. Agencies and their nurses were particularly stressed, which may have contributed to the participants' perceptions that the changes they were seeing in their agencies were overwhelming. In addition, participants in the study were self-selected and nurses who choose to participate in nursing research may be more likely to be committed to nursing excellence and caring as the essence of nursing. All the nurses verbalized a caring commitment to their patients, which may not be representative of the HHN population. Though we made strenuous efforts to recruit a representative sample, the study included a high proportion of BSN nurses and nurses with advanced degrees, which is not likely to be representative of the HHN population. With only one

male nurse and one from a different racial group than the White majority, the diversity of the sample may not be representative of nurses in other home health agencies.

Implications: The results of this study have implications for HHNs, agency leaders, educators, home health researchers and home health policy makers. *Nurse clinicians* should nurture their commitment to caring and CS/PC principles, knowing that even with limited time, these values remain important to high-quality equitable care. They can seek continuing education opportunities that support CS/PC practice and can creatively reflect on innovative ways to bring CS/PC principles into practice despite a changing home health environment. Nurses can also advocate for policies and procedures that support CS/PC practice.

Agency leaders can explore how to balance CS/PC care with economic constraints to optimize outcomes for diverse populations in a value-based payment system. They can consider educational options to build HHNs' CS/PC skills and can support nurses with ways to accomplish their complex job expectations. A review of policies and procedures may reveal negative, unintentional consequences that undermine CS/PC care.

Nursing school educators can use authoritative transcultural teaching-learning guidelines to incorporate CS/PC principles and skills in their baccalaureate curricula,. *Agency educators* can develop robust orientation, preceptorship, and peer learning programs to promote CS/PC skills. Recognizing nurses, especially those trained before 2003, may never have had an opportunity to learn about CS/PC principles, they can provide in-service programs. Case reviews, where nurses discuss difficult cases, can reinforce reflection, critical-thinking, creative-thinking, and resiliency skills and can help HHNs acquire CS/PC knowledge, attitudes, and skills.

Home health care researchers may wish to uncover 'best practice' CS/PC assessment and care planning skills within current economic restraints. Research on the associations

between low-quality CS/PC care and disparities in health outcomes for minority, marginalized or vulnerable populations may lead to mitigation interventions. Finally, agency and Medicare *policy makers* can include HHNs in policy development discussions to represent the perspectives of nurses and patients related to addressing health disparities.

Conclusions

This study uncovered the journey that HHNs travel to assess and plan care for patients of diverse minority, vulnerable and stigmatized groups. These nurses primarily learned how to provide CS/PC assessments and care-planning experientially – by "the seat of their pants." Although many nurses developed a repertoire of CS/PC skills, most nurses felt their educational programs and agencies did not adequately teach them how to provide CS/PC assessments and care planning. Instead they developed their skills through a hit-or-miss, trial and error process that was neither efficient nor effective and could have been detrimental to their patients.

The grounded theory model, *Home Health Nurses' Journey to Culture-Sensitive/Patient-Centered Skills*, may provide a blueprint for identifying and addressing ways to enhance the facilitators and reduce the barriers to CS/PC care. However, it will necessitate the efforts of various stakeholders to assure the requisite commitment, education, resources, and policies to achieve that goal. Ultimately, CS/PC efforts may help mitigate disparities and improve quality outcome indicators.

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CHAPTER SIX – ADDITIONAL FINDINGS

In addition to the findings reported in the previous two chapters, the data provided by the two groups of nurses can also be used to investigate other home health phenomena beyond the process by which home health nurses develop culture-sensitive/patient-centered assessment and care planning processes. For instance, the grounded theory paper only briefly describes several concepts included in the theoretical model, but the data about these concepts is quite rich and can be used to answer other research questions. Below are several additional research questions, and a brief description about additional findings from the home health nurses' and transcultural nurses' data. Several papers are planned so these additional findings can be fleshed out and disseminated in the home health and nursing literature.

How does 'caring' influence culture-sensitive/patient-centered care?

Both the transcultural and home health nurses discussed various dimensions of caring and its role in cross-cultural and patient-centered care. For instance, they described the importance and characteristics of caring as personality traits, attitudes, values, relationships, and practices. One striking finding was how strongly the nurses' felt about the importance of strong nurse-patient relationships were to their ability to adequately assess and understand the patient and to develop care plans to which the patient would adhere. These perceptions, and others about the concept of caring within the data, will be explored and compared to the literature about transcultural and patient-centered nursing

care. An abstract has been submitted to present these findings at the International Association for Human Caring in June 2021.

What are home health nurses' attitudes, knowledge, and skills related to culture-sensitive/patient-centered care and how do they compare to those of transcultural nurses?

During their interviews, the home health nurses revealed their attitudes, knowledge and skills related to culture-sensitive/patient-centered care. These findings will be described in a manner similar to the way they were described in the Chapter 4 paper. Then these attributes will be compared with those of the transcultural nurses. Many of the home health nurses' attitudes were similar to those of transcultural nurses, such as their commitment to caring and its many attributes. However, unlike the transcultural nurses, some nurses revealed implicit biases and feelings of discomfort in dealing with patients from some cultural groups. Compared to the transcultural nurses, home health nurses' lacked knowledge about the principles that guide CS/PC care. They especially lacked knowledge about culture, cultural groups, importance of the patient's culture to health decision-making, how to assess cultural issues, and how to partner with patients to adapt care to cultural preferences. A manuscript about home health nurses' culture-sensitive/patient-centered attitudes, knowledge, and skills and how they differ from transcultural nurses will be submitted to *Home Healthcare Now*.

What are specific culture-sensitive/patient-centered strategies that home health nurses can incorporate into their assessment and care planning skills?

Both the transcultural and home health nurses identified multiple concrete, pragmatic, measurable culture-sensitive/patient-centered strategies that they use in their practice. Despite being time-pressured, participants used these strategies to enhance the cultural-sensitivity and patient-centeredness of their assessment and care planning skills. A manuscript, about how home health nurses can adopt these strategies into their practice, is being prepared. The target journal for this manuscript is the clinical practice journal, *Home Healthcare Now*.

A one-page resource – a tool for helping home health nurses to quickly and easily adopt these strategies into their practice – is being developed. This resource will be given (with permission to distribute freely for clinical and educational purposes) to the funder of this study, the Alliance of Home Health Quality and Improvement. This resource can be posted on their website and distributed to the Alliance's member organizations to assist with agencies' educational and professional development programs to enhance the quality and equity of the care their clinicians provide. Submission by June 2021.

Do nursing schools teach student nurses how to perform culture-sensitive/patient-centered assessment and care planning?

Home health nurses generally felt that their basic nursing education programs lacked adequate quality information about how to be a nurse in a multicultural world. Although this is understandable for nurses who went to nursing school over twenty years

ago, before the importance of CS/PC care was appreciated, many of the nurses who graduated from nursing school since year 2003, felt their educational programs did not provide them with the information they needed to conduct CS/PC assessments and care planning. A paper will be developed to describe home health nurses' critiques of their nursing school education. It will also include their recommendations for how nursing schools can prepare nurses for the real-life situations they encounter. The target journal will be an academic education journal.

What is the role of home health agencies in supporting culture-sensitive/patient-centered care?

Many home health nurses commented on the importance of building warm caring relationships with patients to properly assess and plan care and to successfully teach and achieve good outcomes. The home health nurse participants tended to feel the ability to build caring relationships and to provide CS/PC care was more important in home care than in any other clinical setting because of the unique nature of caring for patients as guests in their homes. They reported instances in which they were unprepared for the personal and cultural situations they encountered and felt that a good orientation program could have educated them in how to be culture-sensitive and patient-centered when caring for patients in their homes. They felt agencies needed to educate nurses about CS/PC care in the home setting, since this nursing in the home is different from, and more important than, facility-based nursing. They had many recommendations, including innovative ones, that agency leaders and educators could adopt to smooth nurses' path

towards CS/PC skills. A paper about their insights, critiques and recommendations will be submitted to *Home Healthcare Now.*

What are home health nurses' perceptions about barriers to providing culture-sensitive/patient centered care?

When asked about barriers to providing culture-sensitive/patient-centered assessment and care planning, the home health nurse participants spent more time talking about why it was difficult to incorporate culture-sensitive and patient-centered principles into their practices than on any other interview question. Although these opinions were briefly mentioned in the grounded theory study, the nurses had much more to say about the negative and unintended consequences of various agency and Medicare policies. The participants discussed their observations and recommendations related to productivity requirements, compensation plans, documentation time, electronic medical records and care delivery models. A tentative title for the article is "What home health nurses would like their agencies and Medicare to know." This paper will be submitted to *Home Health Care Management & Practice.*

APPENDIX A: RAY'S MODEL OF *TRANSCULTURAL CARING DYNAMICS*

Transcultural Caring Dynamics theory consists of four dimensions that contribute to the 5th dimension – the nurse's approach to helping the patient meet health and well-being goals. These dimensions include 1) essence of caring, 2) transcultural caring ethics, 3) transcultural context, and 4) universal sources, which together enable the nurse to practice the 5th and central concept – transcultural caring awareness, understanding and choice – during the care of each patient. Each of the concepts are deeply interconnected and so the concepts are each defined in relation to the other concepts.

1. *Caring as Essence* means that the nurses' caring attitudes, knowledge (grounded in caring science), skills and traits are grounded in a universal source and that they lead to an ethical commitment to provide care to all patients, all of whom are multicultural human beings. Caring is compassion/love united with social justice, where the dignity of each patient is supported and their needs are met. The nurse meets the patient's needs for health, well-being, belongingness and dignity through caring attitudes and actions. These attitudes and actions include 'being with' and available to the patient at a deep level during the nurse-patient encounter and by communicating with empathy, love and compassion. Caring is deeply embedded within the concepts of culturally-competent *care* and patient-centered *care*.

2. *Transcultural Caring Ethics* means the nurse is committed to achieving health and well-being for all patients of all types of diverse groups and cultural norms through caring. Caring is a universal need and therefore everyone has the moral responsibility to care. This ethical perspective is supported by diverse religions (at their purest core) and philosophical perspectives that see caring for and loving one another as the highest ethical principle. Nurses are encouraged to develop their compassion, generosity, fairness, patience, fidelity, truthfulness and thoughtfulness. The nurse should promote patients' human rights to respect, self-determination and the highest possible health outcomes. Caring ethical actions include developing a trusting (therapeutic) relationship with the patient, acting compassionately and fairly, thinking critically and creatively and communicating using spiritual-ethical CARING techniques, as described in Ray's *Communicative Spiritual-Ethical CARING Tool for*

Cultural Competency. The mnemonic CARING in the tool's name stands for compassion, advocacy, respect, interaction, negotiation and guidance.

3. *Transcultural Context.* All patient-nurse encounters are transcultural. Both nurses and patients are multicultural beings since their beliefs, values, and behaviors (cultural norms) are influenced by the multiple cultural groups of which they are members. Multiple cultures interconnect with one another when nurses engage in therapeutic relationships with patients. Nurses and patients are also interacting within the healthcare organization's culture, which also should be grounded in and delivering caring. Caring must emanate from the organization – and its nurses – as it manages the economic, technological, legal, political, educational, physical and social/cultural factors around and within the organization. If services are caring, the universality of the diversity will become more and more pronounced. We will begin to think about how our rich cultural heritages unite us, rather than focusing on what divides us.

4. *Universal Sources* are the founts of knowledge that people use to discover purpose and meaning in their lives. These ultimate sources go by many different names – the Absolute, Allah, Buddha, Brahman, Christ, Cosmic Consciousness, God, other mythological/mystic traditions or philosophical/humanistic principles. On trying to understand the pure core within each, Love is seen as the source, the process, and the end of life's purpose and meaning, manifesting the universality in the diversity. Love is caring and caring is love. The deepest ethical-spiritual principle is caring.

5. *Transcultural Caring Awareness, Understanding and Choice.* All the previous dimensions of transcultural caring seek to facilitate this fifth dimension of the theory. This is where the patient encounter occurs and where the nurse develops the therapeutic relationship with the patient that promotes health and well-being. The nurse uses caring to become *aware* of the patient's cultural and holistic (body/mind/spirit) needs/perceptions/feelings. The nurse seeks to *understand* the patient from the patient's perspective. In dialogue and through caring, the nurse and the patient (family/significant others) *choose* strategies that will help the patient grow towards maintaining health, preventing illness/injury, achieving recovery or easing into a peaceful death. To aid in this process, Ray developed the *Transcultural Communicative Spiritual-Ethical CARING Tool*, in which the mnemonic CARING guides the nurse through the process of specific actions to take during caring nurse-patient encounters.

APPENDIX B: HOME HEALTH NURSING STUDIES ADDRESSING CULTURALLY COMPETENT CARE

Author, year	Title	Research Question	Sample	Methodology	Findings/Conclusions	Limitations
DiCicco-Bloom, 2003	Home care nurses: A study of the occurrence of culturally competent care	How do HHNs identify and manage cultural issues among culturally diverse patients?	14 nurse-patient pairs from two NE HH agencies	Qualitative study using interviews and 3 observational visits per nurse/patient dyads	• Nurses grouped by their patterns of response to cultural difference: *6 nurses ignored culture and cultural issues; *5 nurses addressed cultural differences through an ethnocentric lens; *3 nurses acknowledged differences with an appreciation of their legitimacy; *No nurses were able to adapt care to the patient's cultural needs/preferences; *2 nurses sought support/advice from their supervisors who were not supportive. • "Work needs to be done to integrate current research with the daily practice of delivering health care to patients from diverse cultures"	• Small sample from 2 HHAs in one state; • It is unknown if home care has improved over the last 17 years
Schim et al., 2006	Cultural competence among hospice nurses	What variables are associated with higher levels of cultural competence?	107 hospice nurses from 5 agencies	• Quantitative cross-sectional descriptive study • Regression analysis • Cultural Competence Assessment Tool	• Higher education associated with cultural awareness and sensitivity; diversity training associated with self-reported cultural competence behaviors. • Nursing competence behaviors with the lowest scores were performing	• Convenience sample; • 5 agencies in one state; • Self-reported data

Author, year	Title	Research Question	Sample	Methodology	Findings/Conclusions	Limitations
				(Self-reported diversity experience, awareness/ sensitivity and competence behaviors	and documenting cultural assessments, documenting adaptations to care and using cultural resources to learn about different cultural groups.	
Debesay et al., 2014	Facing diversity under institutional restraints: Challenging situations for community nurses when providing care to ethnic minorities	What challenges do community nurses face when providing care to ethnic minorities?	19 Norwegian HHNs	• Qualitative, hermeneutical • Semi-structured in-depth Interviews	• Conflicts over good care for rehabilitation and palliative care patients (best way to recover, truth-telling); insecurity about personal boundaries across genders. • Nurses feel inadequate because healthcare system doesn't provide education & resources needed to care for diverse populations. • TCN perspective of promoting greater nurse cultural competencies is inadequate in a system with structural barriers.	Data collected in 2008; Norwegian study
Bjarnadottir et al., 2016	Assessment of sexual orientation & gender identity in home health care: Nurses perceived training needs	What are HH nurses' attitudes and perceptions about routine collection of SO/GI data?	14 HHNs from 1 HHA in NYC	Qualitative descriptive study of 4 focus groups	• HHNs reluctant to discuss SO/GI because of fear of causing offense; lack of knowledge of SOGI issues; inadequate knowledge of how to ask appropriately • HHNs need additional training in and knowledge about discuss SOGI issues & how to discuss them	Conducted in NYC

Abbreviation Key: CC=culturally competent; DV=dependent variable; HHA=home health agency; HHN=home health nurse; IV=independent variable; NYC=New York City; SO/GI=sexual orientation/gender identity

APPENDIX C: HOME HEALTH NURSING STUDIES ADDRESSING PATIENT-CENTERED CARE

Author, Year	Title	Country	Terms	Research Question	Sample	Methodology	Findings	Limitations
Schoot et al., 2005a	Actual interaction and client centeredness in home care	Nether-lands	• Client centered • Tailored care	How do pts perceive their interactions with nurses? How do they describe care that is client-centered?	45 clients (patients with chronic illness & their cgs) cared for by 8 nurses from 2 HHAs	• Grounded theory • Observations of 45 client/ nurse inter-actions • 8 clients interviewed	• Clients describe PCC as a collaboration that assures congruence between desired & allowed participation • Barriers to PCC: heavy caseload, task-oriented nursing system	• Sample of only chronically ill/disabled patients in long-term home care • Small sample for interviews
Shoot et al., 2005b	Recognition of client values as a basis for tailored care: The view of Dutch expert patients and family caregivers	Nether-lands	Tailored care	What are patient & caregiver perceptions of how nurses tailor care to their needs?	7 participants representing chronically-ill patients & caregivers of varying ages	• Grounded theory study	• Tailored care occurs during a dialogue where pt/cg & nurse are equal & interdependent partners in quest for pt's QOL • Nurse is attentive & responsive to patient's values; helps patient develop competencies. • Nurse attempts to keep pt's life as close to the way pt wants it.	• Small sample of chronically ill, functionally dependent patients/ caregivers
Shoot et al., 2006	Client-centered home care:	Nether-lands	Client-centered	What are nurses' perceptions of	10 nurses/ auxiliary nurses caring	• Grounded theory	• Nurses have difficulty balancing pts'	• Small sample • Sample included

Author, Year	Title	Country	Terms	Research Question	Sample	Methodology	Findings	Limitations
	Balancing between competing responsibilities			client-centered care?	for chronicallyill patients	• Observation of nurse-pt interactions • Nurse interviews	preferences & agency expectations. • Competing responsibilities to patient & agency result in nurse dissatisfaction and moral distress. • Nurses use 4 interactions	20% "auxiliary nurses" • Description of sample
Brown, 2006	Client-centred empowering partnering in nursing	Canada	Patient empow-erment	How do nurses incorporate client empower-ment principles into care,	8 HHNs	• Qualitative phenomen-ologic study • Hermeneutic analysis	• Nurses had difficulty operationalizing the concept and transitioning from 'expert' to 'partner'; • Nurses had not mastered the mutuality and negotiation skills needed to provide "effective" care.	• Small sample size • Focused on effective-ness of a training program to change care practices.
Leine, 2017	Feeling safe and motivated to achieve better health: Experiences with a partnership-based nursing practice programme for in-home	Norway	Partner-ship as practice	What are COPD patients' experiences with partnership-based care?	6 home-care COPD patients	• Qualitative design with semi-structured interviews	• 'Partnership as practice' enabled pts to feel they 1) were listened to & heard as valued persons; 2) received support that facilitated well-being; 3) participated in an exchange of information based on a trusting relationship,	• Small sample size • Only COPD patients

Author, Year	Title	Country	Terms	Research Question	Sample	Methodology	Findings	Limitations
	patients with COPD						that enabled best decisions. • Partnership is an effective way to meet the complex needs of COPD patients.	
Róin, 2018	Person-centredness in elder care: A secondary analysis of qualitative data	Faroe Islands (Den-mark)	Person-centred	Do older patients perceive they receive person-centered care from their HHNs?	6 elderly partici-pants	• Secondary data analysis of a previous qualitative study about aging	• Elderly pts feel nurses provide care according to the home care system's options and resources, not according to the patient's perceived needs and preferences, which detracts from their QOL	• Small sample • Atypical secondary data analysis of qualitative data

Abbreviations: Cgs=caregivers; HHA=home health agency; HHN=home health nurse; PCC=patient-centered care; pts=patients; QOL=quality of life

APPENDIX D: STRATEGIES TO ASSURE SCIENTIFIC RIGOR

Credibility is related to internal validity since it evaluates how faithfully the researcher's emerged theory represents the phenomenon as experienced and reported by the participants. Credibility is the degree to which what the researcher reports discovering is true of the phenomenon. Some of the methods I will use for enhancing the credibility of this study include: 1) asking experts to check how accurate I was in constructing conclusions from the data shared by the participants (a variation of "member checks"); 2) continual evaluation of previously collected data, and its emerging concepts, against new data from additional participants so that previous interpretations about the meaning of the data are constantly being modified by the discovery of new information (constant comparison); 3) transparency about my perspective, assumptions, values and biases, as defined in the Theoretical Framework discussion; 4) continual reflection (using memoing, a type of journaling) on how my preconceptions and assumptions could influence the various stages of the research and reporting on how they were managed during the study (reflexivity); and 5) providing a "thick rich description" of the study's results by capturing and reporting verbatim quotes from participants' interviews that exemplify the study's concepts.

Dependability and Confirmability are similar to the concept of reliability. Dependability is the degree to which someone performing the same interviews on the same participants would find the same findings. Dependability is strengthened by *memoing* (Corbin & Strauss, 2015), which is an ongoing process throughout a grounded research study. Thus, the researcher will keep a record of methodological and interpretive decision-making through written notes "attached" to interview transcripts. These memos will serve as the basis for developing a report summarizing how decisions were made throughout the study. Confirmability is the degree to which readers of the research can verify the researcher's objectivity. All the strategies that strengthen credibility and dependability build the study's confirmability.

Transferability, sometimes called "fittingness," is analogous to external validity in quantitative research. Transferability is the degree to which the findings may be applied or adapted for nurses beyond the current study. Among the aspects of transferability is the degree to which nurses selected to participate in the study are representative of the population of home health nurses. I will seek transferability in two ways: 1) through *maximal variation of the theoretical sample*, which means that while selecting participants based on the emerging concepts that arise during the study, I will endeavor to recruit a sample that is representative in the different ways that home health nurses differ, such as by age, gender, race/ethnicity and years of experience in home health nursing and 2) by providing information about my perspective and assumptions (See Chapter 1, Theoretical Framework), so research consumers can judge for themselves if the approach I took in interpreting the data is congruent with their own perspectives. This helps other nurses decide if the findings are transferable to their own situations and settings. This part of transferability is also important to credibility.

APPENDIX E: STRATEGIES TO ADDRESS ETHICAL ISSUES

Right to Privacy

Protecting participants' *right to privacy* includes asking questions that are pertinent to the study, respectfully honoring a participant's desire not to disclose certain types of information, conducting interviews in private locations, assuring only the researcher and participant are involved in the interview, and assuring that all data collected is protected from access by others apart from the research team.

Right to Confidentiality

The *right to confidentiality* is a subset of the right to privacy, which, in this study, means that all participant-identifiable information/data is protected from availability or access to anyone other than the participant and the research team. In grounded theory research, Corbin and Strauss (2015) specifically recommend assigning and using pseudonyms to identify participants. All recording files and transcripts will be labeled only with these pseudonyms. Using pass-word protected computers, locked offices, and a secure way of destroying data post-publication, also protects participant confidentiality. Specific procedures for protecting this study's participants' right to privacy and confidentiality are outlined in the data collection and management processes included in the *Methodology* section of this proposal .

Right to Welfare

Participants' right to welfare means participants' physical, emotional, and financial health and well-being will not be harmed. Any physical or financial harm is improbable. Emotional harm is unlikely, but it is possible that some participants could experience feelings of embarrassment, shame, or disappointment as they reflect upon their feelings about, and responses to, patients of diverse backgrounds. Through the self-reflection required by the interview, they may discover they harbor biases towards, or provided inadequate care to, patients of marginalized groups, which they may find upsetting. Care will be taken to avoid probing questions which would lead to painful feelings. If such insights/conclusions are verbalized during the interview, the researcher will need to balance the role of researcher with the emotional needs of the participant. One way to do this could be with a post-interview debriefing, during which the researcher would provide support that may help assuage painful feelings and move the participant to personal growth.

Right to Self-Determination

The participant's *right to self-determination* will be protected by developing a comprehensive understandable *Informed Consent* document, built on the *GMU Informed Consent Template* (See Appendices B and C). This template is written at a 12th-grade reading level, so it is appropriate for the nurses who will participate in the study. It prompts information that must be included in the consent: the purpose of the study, the study's interview procedures, potential risks to the participants (none foreseen, except time and effort), benefits to participants (none anticipated, other than perhaps helping to enhance the care of home health patients), and how the participant's privacy, confidentiality and welfare will be protected. The consent will also explain the participant's self-determination rights, including the right to decline to participate, the right to have all questions answered, and the right to withdraw from the study at any time. Contact information for the researcher and faculty advisor will be included so all questions can be answered, and all concerns can be voiced. A place for the participant to provide written consent, including a special notation about giving consent for audio taping of interviews, are included at the end of the consent form. This form will be reviewed with the participant prior to the starting the interview.

APPENDIX F: INFORMED CONSENT – TRANSCULTURAL NURSE FOCUS GROUP

Permission for Participation in Research: Informed Consent Form (Focus Group Participant)

Contact Information:
Mary Narayan, MSN, RN, CNS
(703) 648-0222 mnarayan@gmu.edu

RESEARCH STUDY TITLE: Home Health Nurses' Assessment and Care Planning Skills in Home Health Nursing

RESEARCH PROCEDURES

This research is being conducted to explore how home health nurses perform assessments and care planning. This focus group provides a venue for transcultural nurses to share their insights and opinions with their colleagues and the researcher about good assessment and care planning practices. If you agree to participate, you will meet with the researcher and a maximum of 12 participants in a private room for an audio-taped discussion. The discussion will last about 60 – 90 minutes.

This study is being funded by the Alliance for Home Health Quality and Innovation.

RISKS

There are no foreseeable risks for participating in the focus group for this research study.

BENEFITS

There are no direct benefits to you as a participant other than to further knowledge about assessment and care planning. This research may lead to recommendations and practices which enhance the quality of home health nursing practice.

CONFIDENTIALITY

The data in this study will be confidential. Although focus group participants will be asked to keep the contents of the discussion confidential, due to the nature of a focus group, the researcher cannot control what participants might say outside of the research setting. Participants will be asked to preserve confidentiality at the beginning and end of the discussion. A pseudonym (fake name) will be used to identify each focus group participant. When the audiotape is being transcribed, real names will be replaced by the pseudonyms. The pseudonym will also be used for any demographic information you provide. A key to your real name and pseudonym will be placed in a password-protected file that is only accessible by the research team. Audio-files will be deleted at the end of the study. The focus group data (only identified with pseudonyms) may be used for future research without additional consent of group participants.

PARTICIPATION

You are eligible to participate in the study if you: 1) are a registered nurse, 2) are interested in high-quality care for culturally diverse patient populations, and 3) you agree to audiotaping of the focus group discussion. Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate, or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party. You may choose not to answer any question that is posed to you or the group. Your participation in this focus group will not be shared with your employer.

As a token of appreciation for participating in the study, you will receive light lunch and a $10 Amazon certificate at the end of the focus group session.

CONTACT

This research is being conducted by Mary Narayan, a doctoral nursing student at the George Mason University School of Nursing. Mary's faculty advisor is Dr. R. Kevin Mallinson, PhD, RN, also at the School of Nursing. Please contact them for any questions or to report a research related problem:

- Mary Narayan: (703) 648-0222 or mnarayan@gmu.edu
- R. Kevin Mallinson: (703) 993-1941 or rmallins@gmu.edu

You may also contact the George Mason University Institutional Review Board at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT

I have read this form, all of my questions have been answered by the research staff, and I agree to participate in this study.

_____ _____

Name/Signature Date of Signature

If you would like to receive an emailed summary report of the findings of this study when it is done, please provide a valid email address:

Please check one:

_____ I would like to receive a summary report.

Email: _____

_____ I do not wish to receive a summary report.

APPENDIX G: INFORMED CONSENT – HOME HEALTH NURSE INTERVIEWS

Permission for Participation in Research: Informed Consent (Interview Participant)

Contact Information:
Mary Narayan, MSN, RN, CNS
(703) 648-0222 mnarayan@gmu.edu

Research Study Title: Home health nurses' assessment and care planning practices

Research Procedures. The interview will be conducted in a confidential setting of your choice (e.g., your home, private room at your agency, etc.) or online using Webex. to discuss your nursing assessment and care planning practices. This study is being funded by the *Alliance for Home Health Quality and Innovation*.

Risks: There are no foreseeable risks for participating in this research.

Benefits: There are no benefits to you as a participant other than to further knowledge about home health nursing. This research may lead to recommendations and practices which enhance the quality of home health nursing practice.

Confidentiality: The data in this study will be confidential

- For those participating via Webex: While it is understood that no computer transmission can be perfectly secure, reasonable efforts will be made to protect the confidentiality of your transmission. Participants may review Webex's website for information about their privacy statement at https://www.webex.com/cisco-privacy_full-text.html
- Webex's audio/video recording will be converted to an audio-only file immediately after the interview and the audio/video file will be destroyed after creation and verification of the audio file.
- A pseudonym (fake name) will be used to identify your audio-file and transcript. Your name will not be associated with the data. A key to your real name and pseudonym will be placed in a separate password-protected file.

- Your audio-file and transcript will be kept on a password-protected computer. Any hard copies related to the research will be kept in a locked office.
- Only the research team (researcher and three dissertation committee members) will have access to your interview data.
- Audio-files and transcripts (only identified with pseudonyms) could be used for future research without additional consent of participants.
- Files will be destroyed five years after completing the study, unless being used for additional research.

Participation: Your participation is voluntary, and you may withdraw from the study at any time and for any reason.

- If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled.
- There are no costs to you or any other party.
- You may choose not to answer any question that is posed to you.
- Your participation in this study interview will not be shared with your employer.
- You have a right to have all your questions about this study answered prior to, or at any time during, this study.
- As a token of appreciation for participating in the study, you will receive a $10 Amazon certificate at the end of the interview.

Audio/video taping:

Your interview comments will be audio-recorded in order to obtain an accurate record for research analysis. Information about the management and destruction of your audio-file is included in the *Confidentiality* section above.

_____ I agree to audio or audio/video-taping.

_____ I do <u>not</u> agree to audio or audio/video-taping.

Contact:

- This research is being conducted by Mary Narayan, a doctoral nursing student at the George Mason University School of Nursing. Mary's faculty advisor is Dr. R. Kevin Mallinson, PhD, RN, also at the School of Nursing. Please contact them for any questions or to report a research related problem:
    - Mary Narayan: 703-648-0222 or mnarayan@gmu.edu
    - R. Kevin Mallinson: 703-993-1941 or rmallins@gmu.edu
- You may also contact the George Mason University Institutional Review Board at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.
- This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT
I have read this form, all of my questions have been answered by the research staff, and agree to participate in this study.

_____ _____
Name/Signature Date of Signature

If you would like to receive an emailed summary report of the findings of this study when it is done, please provide a valid email address:

Please check one:

_____ I would like to receive a summary report.

Email: _____

_____ I do <u>not</u> wish to receive a summary report.

APPENDIX H: TRANSCULTURAL NURSE DEMOGRAPHICS

Participant	Age	Male/ Female	Race/ Ethnicity	Location in USA	Nursing Experience	Home Health Experience	Role	Degree	Certification
P1	65	Female	W	West	25	0	NP	PhD	FNP
P2	62	Female	W	Southeast	40	3	Educator	MSN	CTN-B
P3	35	Female	W	Northwest	15	0	Educator	MSN	
P4	46	Female	W	Canada	22	16	Educator	MSN	PMHN
P5	37	Female	W	Northeast	15	0	Educator	PhD	PNP
P6	29	Female	W	Northeast	4	0	NP	DNP	FNP
P7	71	Female	W	West	50	5	NP	MSN	CTN-A
P8	54	Female	W	Northeast	35	3	Clinician	MSN	CTN-B
P9	37	Female	W	Northeast	10	0	Clinician	MSN	

APPENDIX I: HOME HEALTH NURSE DEMOGRAPHICS

Participant	Age	Male/ Female	Race/ Ethnicity	State	Nursing Experience	Home Health Experience	Role	Agency Type	Degree	Life Experiences
P1	66	Female	White	VA	45 yrs	45years	Clin/CNS	FP	BSN	no
P2	26	Female	White	FL	4	2	Clin/Qual	FP	BSN	no
P3	68	Female	White	VA	35	20	Clin/CM	FP	AD	no
P4	64	Female	White	VA	43	27	Clin/CM	FP	BSN	no
P5	52	Female	White	VA	27	14	Clin/CM	FP	BSN	yes
P6	63	Female	White	MA	44	24	Sup/Edu	NFP	AD	no
P7	41	Female	White	TX	20	3	Clin/CM	FP	Master's	no
P8	57	Female	White	PA	37	27	Sup/Adm	FP	BSN	no
P9	57	Female	White	PA	13	13	Clin/CM	NFP	AD	yes
P10	27	Male	White	VA	5	1	Clin/CM	FP	BSN	yes
P11	42	Female	White	MS	12	6	Clin/Sup	NFP	BSN	no
P12	66	Female	White	FL	40	30	Educator	FP	MSN/MA	no
P13	63	Female	White	MD	30	5	Clin/CM	NFP	MSN	yes
P14	68	Female	White	CA	42	40	Clin/Qual	FP	BSN	yes
P15	55	Female	White	MD	30	27	Clin/CM	NFP	BSN	no
P16	63	Female	White	WI	41	34	Clin/CNS	FP	MSN	no
P17	64	Female	White	MI	42	28	Sup/Edu	NFP	AD	no
P18	31	Female	Black	AZ	10	4	Clin/CM	FP	BSN	yes
P19	25	Female	White	PA	4	2	Clin/CM	FP	MSN	no
P20	48	Female	White	VA	25	23	Clin/CM	FP	BSN	yes

Abbreviations: Clin=clinical, CM=case manager, Sup=supervision, Edu=Educator, FP= for-profit, NFP=not-for-profit, Life experiences = parents or spouse of different cultural group(s)

APPENDIX J: RECRUITMENT FLYER FOR TRANSCULTURAL NURSES

GEORGE MASON UNIVERSITY

Seeking Transcultural Nurses for Focus Group

(Friday, October 18, 12:15 pm, Omni's Canal Room, Light Lunch)

Purpose:

- This dissertation research study is exploring 'good' assessment and care planning practices for home health nursing
- Study is being conducted by Mary Narayan, a PhD student at the George Mason University School of Nursing.

Eligibility: You are eligible to participate in the study, if you:

- Are a registered nurse
- Agree to audio-taping of the discussion
- Are interested in high-quality care for culturally diverse patients
- *Experience in community/home health nursing a plus, but not necessary*

Participation:

- Focus group will be held on **Friday, October 18, 12:15 pm in the Canal Room,** here in the Omni Hotel.
- Focus group limited to 12 participants, on first-come, first-served basis.
- Focus group discussion will last about 60 - 90 minutes.
- You will be asked to complete a brief demographic questionnaire.
- Participants will receive a light lunch and a $10 Amazon gift card in appreciation of their time and participation.

Contact: To learn more, call or text Mary Narayan at 571-242-4193 or send an email to mnarayan@gmu.edu.

Principal Investigator: R. Kevin Mallinson, PhD, RN
Associate Professor/Division Director, PhD Program,
School of Nursing, George Mason University
(703) 993-1941 rmallins@gmu.edu

This research study has been approved by the Institutional Review Board of the George Mason University in Fairfax, VA
IRBNet Number: 1450243-1

APPENDIX K: RECRUITMENT FLYER FOR HOME HEALTH NURSES

Home Health Nurses

Needed for Research Study Interviews

Purpose:

- To explore nurses' assessment and care planning processes.

Eligibility: You are eligible to participate in the study if:

- You are a home health nurse with at least one year of experience **AND**
- You assess and plan care for home health patients.

Participation: You will:

- Engage in a 60-minute audiotaped interview with the researcher & complete a brief demographic survey.
- Receive a $10 Amazon gift card to thank you for your time and participation.

Contact: To learn more, contact Mary Narayan at mnarayan@gmu.edu

Study conducted by Mary Narayan, MSN, RN, a PhD student at George Mason University's School of Nursing.

Principal Investigator: R. Kevin Mallinson, PhD, RN, Associate Professor/Division Director, PhD Program, School of Nursing, George Mason University, (703) 993-1941, rmallins@gmu.edu

This research study has been approved by the Institutional Review Board of George Mason University [IRBNet Number: 1450243-2]

GEORGE MASON UNIVERSITY

APPENDIX L: INTERVIEW GUIDE FOR INTERVIEW PARTICIPANTS

- Describe how you usually assess and plan care for your newly admitted patients?
  - What kinds of challenges do you encounter when performing these skills?
- How does culture influence how you care for patients (B. DiCicco-Bloom & Cohen, 2003)?
  - What do you think about when you hear the term ‘culturally-competent care’?
  - From your perspective, what are the key elements for care to be culturally-competent?
  - How do you make your care culturally competent?
- What do you think about when you hear the term ‘patient-centered care’?
  - From your perspective, what are the key elements for care to patient-centered (Fix et al., 2018b)?
  - How do you make your care patient-centered?
- What helps/has helped you provide culturally-competent care?
  - Patient-centered care?
- What challenges or barriers affect your ability to provide culturally-competent care?
  - Patient-centered care?

APPENDIX M: DATA ANALYSIS METHODS

In grounded theory, data analysis begins with the first interview and continues throughout the interviews in an iterative process. The grounded theory techniques used to analyze the data include constant comparison, memoing, open coding, axial coding and selective coding (Corbin & Strauss, 2015).

Constant comparison. The researcher constantly compares the data from each new interview to the data previously collected. Constant comparison is key to the recursive process of simultaneous data collection, analysis and theoretical sampling.

Memoing. To maintain a record of insights, reflections and decisions related to interview analysis, the researcher keeps a journal. For instance, memoing can be used to capture thinking about next steps in the theoretical sampling strategy. Memoing will help the researcher create a kind of "audit trail," enabling the researcher to summarize the process used during the study.

Coding. The researcher breaks down and reconstructs the data into categories during three sequential stages of coding: open, axial and selective coding stages.

Open coding. During the first coding stage, the researcher uses a wide lens to identify and apply labels to themes in the data. In this stage, interviews are analyzed in their entirety, pulling out and coding all the themes within the interview. Gradually the codes will start clustering into categories, and as the open coding continues, some of the categories will become deeper and denser. One of these categories will likely emerge as the 'core category,' the most significant theme, through the density of its coded data.

Axial coding. During the second coding stage, the researcher transitions from a structured analysis of the data to a more inductive, abstract and interpretative perspective. Four types of categories are arranged around the core category: causal conditions, strategies, intervening conditions and consequences. During this stage, the researcher reviews the transcripts, categories, memos and related literature to uncover relationships between the core concept and the other categories. Eventually this process will enable the researcher to transcend the data, making an inductive and cognitive leap into insights that explain how all the concepts are related to one another (Polit & Beck, 2016).

Selective coding. In the final stage of coding, the researcher develops propositions and/or hypotheses about the relationships of the core category to the other categories. The goal during this phase is to develop a model illustrating a substantive theoretical framework. The data can then be re-presented as a diagram, that explains how home health nurses make assessment and care planning decisions for patients from different cultural groups and the factors that influence those decisions (Polit & Beck, 2016).

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BIOGRAPHY

Mary Curry Narayan is a Home Health Clinical Nurse Specialist, certified by the *American Nurse Credentialing Center*. She is also a Certified Transcultural Nurse – Advanced through the *Transcultural Nursing Society*. She received her BSN degree from Cornell University and MSN degree from George Mason University.

Mary has extensive experience in home health nursing, primarily as a clinician and educator. Her career includes a two-year service commitment as a nurse in a Yupik village in western Alaska, which inspired her interest in nursing across cultures. Specializing in both cross-cultural healthcare issues and home health nursing, Mary currently provides consultant and education services, such as in-services, presentations, and educational modules on ways clinicians, especially home health nurses, can better meet the needs of diverse patient populations.

Mary has authored multiple publications including book chapters, peer-reviewed articles and CEU courses about cross-cultural and home health care. She has also presented nationally and internationally to diverse audiences on diverse home health and cross-cultural topics. Mary has served on the American Nurses Association's Task Force for the *Scope and Standards of Home Health Nursing Practice* (2007, 2014) She has been an Editorial Board Member for *Home Healthcare Now* (formerly *Home Healthcare Nurse*) for over 20 years. Mary was one of the founding members of the *International Home Care Nurses Organization* and continues to serve on their Advisory Council.

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