An Exploratory Study of Student Nurses’ Experience in Intercultural Encounters in Clinical Practice

Chun Hua Shao (Joy) 邵淳华
MSc, PGDE, BSc (Hons), FHEA, RNT, RGN
Faculty of Health & Life Sciences, Northumbria University
A Mary Seacole Development Award Supported by Health Education England
Acknowledgements

I would like to take this opportunity to express my sincere gratitude to the funder of the Mary Seacole Awards, Health Education England supported by the Department of Health, NHS Employers, Royal College of Nursing, Royal College of Midwives, UNISON and Unite CPHVA. Many thanks also to the members of the award steering group for their continued support throughout the project.

Special thanks must be extended to my mentors, Dr David Foster and Dr Janet Scammell, for their humble and inspirational supervision, dedicated guidance, tireless attention to detail, heartfelt understanding and endless support. Without their help, I could not have achieved all that I have to this day.

I am also grateful for the support and encouragement received from my managers (Professor Amanda Clark and Sue Jackson) and colleagues (Professor Pauline Pearson, Dr Alison Steven, Margo McKeever, Julia Charlton, Dr Linda Mages, Dr Alison Machin) from the Faculty of Health and Life Sciences at Northumbria University as well as my doctoral study supervisor (Dr Prue Holmes) from School of Education at Durham University.

Furthermore, I also would like to thank the student nurses who participated in this exploratory study; without their trust, time and commitment, this project could not have been completed.

Last, but not least, I wish to say a big thank you to my parents (Dr Shanda Shao 邵善达 & Hongyu Wu 吴红玉) and brothers (Dr Juntao Shao 邵俊涛 & Chuntao Shao 邵淳涛) for their persistent encouragement, inspiration and help; and to my husband (Zhiqiang Xu 徐志强) and two sons (Joshua Yihe Xu 徐懿鹤 & Maximus Yijia Xu 徐懿嘉) for their endless love, understanding and support throughout this journey.

Without the great effort of many individuals, this project would not have been accomplished, so thank you everyone once again!

29th January 2016
Executive Summary

Background

The Black and Minority Ethnic (BME) population has increased significantly over the course of the last three decades (Office of National Statistics (ONS), 2011). This trend is set to continue. Many of these people may require healthcare responsive and sensitive to their diverse cultural needs and religious beliefs. Since the late 1990s, the Department of Health (DH) has established a series of policies which seek to address the multicultural nature of the British society, and requires practitioners to provide care that is appropriate to the whole population which is equitable and fair (DH, 1997, 1999, 2000, 2005, 2008). However, some research (Lim et al., 2004; Stevenson & Rao, 2014) shows that, at times, intercultural practice in healthcare services is still inadequate, with likely negative consequences for the health and wellbeing of patients from BME backgrounds.

Intercultural competence (ICC) is the key in providing effective and culturally responsive healthcare services to ethnically and culturally diverse patients. Nevertheless, Vydelingum’s study (2006) highlighted that nursing staff has demonstrated inadequate ICC, including: a tendency to treat BME patients the same and provide ethnocentric nursing care, which affect the quality of service provision. It is believed that healthcare educators and clinical mentors are important in role modelling and fostering the requisite intercultural competence for our next generation of healthcare professionals (Donaldson & Carter, 2005; Scammell & Olumide, 2012). So far, much research is from the perspective of patients and qualified staff (Harris et al., 2013; Kalra et al., 2009; Priest et al., 2015). Therefore, it is important to investigate the intercultural experiences of future nursing workforce to identify how they perceive intercultural health care. Views and experiences expressed will help to reveal issues encountered when student nurses learn how to provide effective intercultural bedside care and when working with multidisciplinary teams.

My personal experience of living in the UK, as an overseas nurse, a patient from a BME background, and a carer (of a father and sons who have been patients in hospital), has enabled me to gain first-hand experience of both sensitive and insensitive intercultural care. In addition, my role as senior lecturer for pre-registration nursing students also triggered my interest in carrying out a project which seeks to address understanding of intercultural encounters among student nurses, clinical healthcare practitioners, and the BME community.

Aims

This project aimed to explore issues and research techniques as a prelude to a larger doctoral study, which explores student nurses’ experience of intercultural encounters during their clinical placements on hospital wards in England.
Approach

A qualitative research approach was chosen to explore the rich experience of intercultural encounters from the perspective of student nurses. Following ethical approval, four participants (two first-year and two final-year pre-registration nursing students) took part in one-to-one semi-structured interviews. A thematic analysis approach was adopted to analyse the data generated from these interviews.

Key findings

- All participants appeared to have a good understanding of intercultural care competence and desired to further develop their intercultural knowledge and communication skills.

- When a shared language is lacking, student nurses had concerns about the quality of care they delivered. White British students' experienced more frustrations than those from BME backgrounds.

- A variety of verbal and non-verbal approaches were initiated to overcome these linguistic challenges, with some positive outcomes.

- Even though the student nurses valued the importance of accessing accredited interpreter services, they found that the service gatekeepers (qualified nurses) were less keen to use interpreters, due to financial constraints, long waiting times, concerns about interpreter's competence, and lack of understanding about the importance of communicating in the appropriate language.

- The relatives of patients were common facilitators of communication with non-English-speaking patients. However, concerns were raised about using family members as interpreters on grounds that they lacked clinical understanding, compromised patient's confidentiality and difficulties in their availability.

- Student nurses from BME backgrounds perceived that they were viewed negatively by colleagues in their placements, and this resulted in increased stress levels. Such experiences made BME students feel under-valued, doubted and emotionally hurt. Some even considered leaving the course. Their strong resilience, willpower and commitment helped them remain on the programme.

Recommendations

1) Service providers and managers
   - To provide further training to develop staff (both qualified and support workers) awareness, sensitivity and competence in intercultural care.
   - To address the importance of accredited interpreters and encourage use of a variety of interpreting facilities to assist intercultural communication with limited English proficiency patients.
• To provide laminated booklets with picture and key vocabulary in major languages, and linguistic apps at every ward for staff and students caring for patients who require linguistic support.
• To raise awareness of the vulnerability of student nurses from BME backgrounds and promote sensitive working approaches by qualified professionals and support workers.
• To establish and maintain a welcoming and supportive clinical learning environment that supports the learning and wellbeing of BME students.

2) University and academics
• To provide resilience training, advice and guidance from the early stages of student nurse training.
• To include more cultural related information and discussion in pre-registration nursing curriculum, such as cultural beliefs, religious practice, and epidemiology of various diseases in different population.
• To invite former patients and staff from BME backgrounds to talk about their intercultural care experience in clinical practice.
• To encourage and facilitate nursing students to share and exchange experiences of intercultural encounters during placement.
• To encourage students from BME backgrounds to inform and discuss unfair treatment (from qualified and unqualified staff) with their mentors and academic staff.
• To investigate, liaise and take action with placement managers when BME student nurses encounter discrimination and racism on placement.

3) Accredited interpreter services
• To increase the accessibility and availability of accredited interpreters.
• To develop existing interpreters’ competence by providing further healthcare knowledge training.

Conclusion

This report outlines background and aims of the research, methodology, key findings and recommendation for service providers and managers, university and academics, as well as accredited interpreter service. Despite healthcare organisations in the United Kingdom (UK), such as NHS England, The Department of Health (DH), Nursing and Midwifery Council (NMC) and NHS Foundation Trusts, being publicly committed to improving race equality standards, this small-scale study shows that there are continuing concerns about how changes are being brought about in very real situations for patients and student nurses. My years of experience living in the UK and my roles as an overseas nurse, senior lecturer for pre-registration nursing students, clinical practice link tutor and recipient of the prestigious Mary Seacole Award (MSA), have served to increase my passion to develop a more interculturally competent nursing workforce and to improve healthcare services for people from BME communities.
1. Introduction

The 1991, 2001 and 2011 UK censuses indicate a significant increase in the number of people from Black and Minority Ethnic (BME) groups (Office of National Statistics (ONS), 2011). This trend is set to continue. Many of these people may require healthcare different to indigenous people, due to their diverse cultural needs and religious beliefs (Stevenson & Rao, 2014). In response to the diverse needs of the BME group, the Department of Health (DH) has developed policies which acknowledge that Britain is a multicultural society with diverse needs, and which require practitioners to make their care provision in a manner sensitive and responsive to cultural and ethnic diversity. For instance, the Patient’s Charter (DH, 1997) sets out patients’ expectations of standards of healthcare; Our Healthier Nation (DH, 1999) provides a strategic plan to minimise health inequalities; The Vital Connection (DH, 2000) presents an equalities framework for the National Health Services (NHS) and national targets; NHS Race Equality Scheme (DH, 2005) and NHS Constitution for England (DH, 2015) further promote race equality.

However, several studies (Gilbert, 2003; Karlsen, 2007; Stevenson & Rao, 2014) reveal that health outcomes for ethnic minority groups are still much poorer than those of their white counterparts, mainly due to difficulties in access to healthcare services, where organisations have not provided adequate culturally and linguistically appropriate service to meet the needs of people from a different cultural background. Vydelingum’s study (2006) highlights that nursing staff demonstrate inadequate intercultural competence, including: a tendency to treat BME patients the same and provide ethnocentric nursing care, which affect the quality of service provision.

It is believed that clinical mentors and academic educators are key in role modelling and fostering the required intercultural competence for our next generation of nurses (Donaldson & Carter, 2005; Nursing & Midwifery Council (NMC), 2012; Scammell & Olumide, 2012). A variety of materials and programmes have been established for developing nursing students’ effective
communication skills and knowledge in intercultural discourse. However, some of these programmes were reported as not providing sufficient training for students to handle intercultural communication effectively (Gerrish et al., 2004; Koskinen et al., 2008).

From a personal perspective, as an internationally recruited nurse in Britain, I have had a number of first-hand experiences with the NHS from various perspectives: as a staff nurse, a patient, a carer and a nurse educator. Following a period of adaptation, I involved in providing bedside nursing care to patients from various ethnic and cultural backgrounds, and voluntarily helped patients and staff requiring Mandarin Chinese interpreting. As an acutely ill patient, I received excellent nursing care from the multidisciplinary team. Three episodes of family members’ hospitalisation allowed me, from a carer’s perspective, to witness hospital healthcare provision for BME patients. My 11-year-old son, born and raised in the UK, was fluent in English but was surprised by the limited communication with the nursing staff. He wondered why the staff were not speaking to him in the same way as other children in the same hospital ward. My father, a consultant surgeon in China, was surprised by the limited information given by the healthcare providers during his hospital stay. As a nurse educator, I also hear emotional stories about student nurses’ intercultural encounters in clinical practice.

These professional and personal experiences inspired me to conduct research to explore the student nurses’ experience of intercultural care practice in order to gain a better understanding of their perception of intercultural care competence and to identify any issues encountered and strategies employed. This will provide an insight which could inform the practice of healthcare professionals and education providers to further improve healthcare service for people from BME communities.
2. Indicative Literature

This section introduces key concepts and terms (printed in bold) referred to in this project, and discuss the literature about the intercultural education in the British universities that provide healthcare pre-registration programmes. More terms are defined in the Glossary.

2.1 Key terms

Having reviewed the literature, culture in this study is referred as the shared beliefs, values, and language of a group of people (Papadopoulos, 2006). Whilst cross-culture is defined a static ‘in-between’ position when encounter different culture to one’s own, Interculture means an interactive process among these positions (Feng et al., 2009). Therefore, an intercultural encounter is a situation when student nurses meet and interact with another person (or group of people) who have a different cultural background during their placement period (Barrett et al., 2013). This may involve patients and healthcare staff from different countries, regions, or linguistic, ethnic or religious backgrounds. When the interaction is between student nurses and patient, it is referred to as an intercultural care encounter (ICE).

Competence in this context is not only a list of skills which can be applied in a situation, but a combination of attitudes, knowledge, understanding and skills applied through action in any relevant situation (Feng et al., 2009). An intercultural care encounter is one such type of situation. Therefore, intercultural competence (ICC) means the overall capacity to respond successfully to cross-culture situations and to handle tasks, difficulties, challenges or even opportunities for the individual - either singly or together with others (Deardorff, 2009). Fantini (2000) also commented that an interculturally competent practitioner has the abilities to develop and maintain relationships, attain compliance and obtain cooperation with others through effective communication. Deardorff (2009) describes effective intercultural communication as a reciprocal information-exchange process, which requires an open, respectful and understanding attitude towards people who
have a different background. This means that effective intercultural communication needs not only to be able to express oneself freely, but also a willingness to listen and the ability to understand the views of others.

2.2 Intercultural policies and education in British healthcare programmes

In order to establish and maintain a good therapeutic relationship, nurses and other healthcare professionals are required by profession to be empathetic and effective intercultural communicators (Cowan, 2009; NMC, 2015), since it is through effective communication that important information is collected from patients and the required treatment provided (Koskinen et al., 2008). From the 1990s, the Human Rights Act (1998), the Race Relations Amendment Act (2000) and DH policies (1997, 1999, 2000) have acknowledged the diverse needs of the United Kingdom’s multicultural society. The DH (2005; 2015) requires healthcare professional to create culturally safe environments; and NMC (2002) Code of Professional Conduct also requires that staff nurses should treat patients with respect and dignity irrespective of patient’s ethnic or cultural background. However, Culley (2001) argues that legislation and policies alone cannot tackle value and negative attitude which persist in the minds of individuals.

It is recognised that intercultural competences can be developed through different types of learning, including formal education (such as systematically designed topic- or theme-focused intercultural programmes at higher education institutions), non-formal learning (also called ‘experiential learning’ or ‘learning by doing’), and informal learning (such as travel and living abroad, meeting people at different social situations). Fleming (2009) suggests that blending informal learning, experiential surface learning, and formal education is the most effective methods to help students become intercultural competent practitioners. Therefore, it is necessary to explore the literature regarding cultural diversity training at British universities providing healthcare professional education.
Bentley and his colleagues (2008) conducted a comprehensive nationwide survey of cultural diversity training for UK healthcare professionals. They included courses in medicine, nursing, physiotherapy, occupational therapy, speech and language therapy, and pharmacy. This study revealed that about one-quarter of healthcare educational institutions were not offering cultural diversity educational programmes for their students (Bentley et al., 2008). Even in those universities where intercultural education takes place, the survey also revealed a significant difference in the content, teaching methods and amount of teaching and learning in syllabi (Bentley et al., 2008). This study concluded that the cultural diversity training is inadequate in major healthcare programmes, which may lead to students' lack of required intercultural competence before they are qualified.

It was also highlighted that certain parts of England, where BME groups represent a relatively small proportion of the population, less intercultural training was provided in comparison to places with higher percentages of minority residents. Bennett (2006) argues that certain universities' lack of awareness of the ethnic proportions of the local population may contribute to a neglect in provision of intercultural competence training. Therefore, the institutions in these regions may feel little imperative to offer specific content to address the needs of minority groups (Bentley et al., 2008). However, these attitude fail to consider that there is still a relatively large absolute number of BME groups who live in such regions (ONS, 2011). Moreover, there are still large numbers of the BME population who migrate across different regions in the UK (ONS, 2013). In addition, ethnic minority people have a tendency to disproportionately develop certain diseases. For example, South Asian migrants have a higher tendency to develop coronary heart disease than white British, and some minorities have a higher mortality and prevalence of complications (Forouhi et al., 2006).

Leishman (2004) also revealed that British nursing education offered little cultural diversity component in the UK, and believed that the knowledge and skills training did not adequately prepare student nurses to apply relevant knowledge to practice. Student nurses also expressed the need for training to
improve their intercultural awareness and competence in their clinical practice (Leishman, 2004). In response to the needs for a change in attitude and approach to nurse education, RCN developed Transcultural Learning Resources (Husband & Torry, 2004), which is free to access and downloadable at RCN website.

More than a decade has passed since Leishman’s study. During this period of time, nursing education has moved to all-degree level pre-registration. These programmes aim to ‘underpin the level of practice needed for the future’ (NMC, 2010, p.8). Therefore, in the light of this change, it is important to find out whether current British nursing students feel better prepared for their intercultural care, particularly in consideration of the significant increase in BME communities in the past decades.

3. Aims and Research Questions

This pilot project aimed to explore issues and research techniques as a prelude to a larger doctoral study, which will explore student nurses’ experience in intercultural encounters during their clinical placement in England. In order to address this, the following research questions (RQ) were raised, with further subsumed questions.

RQ1: What are student nurses’ perceptions of intercultural competence?

RQ2: In practice, how do student nurses communicate with people who they perceive as having a cultural background different to themselves?

- What challenges do they encounter?
- How do they manage these challenges?
- How effective were their management strategies?
4. Methodology

This section will outline the research methodology, ethical considerations, the process of recruiting participants and collecting data, and methods of data analysis.

4.1 Research approach and recruitment process

In comparison to quantitative approaches (such as surveying), qualitative approaches are able to uncover the unquantifiable dimensions of experience (the whys, hows, contexts and experience) to gain a more comprehensive understanding of the object of study, and to make sense of it in terms of individual meaning-making (Marshall & Rossman, 2011). Therefore, a qualitative approach was chosen to develop a comprehensive understanding of nursing students' experiences in intercultural encounters.

Ethical approval was obtained from the participants' university (appendix I), a purposive sample of first- and final-year pre-registration adult nursing BSc programme students at one institution of higher education in the north-east of England who had experienced intercultural care was recruited. This involved a combination of invitation emails and classroom recruitment, between June and July 2015. Four nursing students (two from year one and two from year three, one of each year group was of BME origin - see table 1) participated in this pilot study.

<table>
<thead>
<tr>
<th>Year</th>
<th>Pseudonym</th>
<th>Gender</th>
<th>Age</th>
<th>Country of origin</th>
<th>Years lived in England</th>
<th>Interview length (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>Bacchus</td>
<td>Male</td>
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<td>BME</td>
<td>11</td>
<td>114</td>
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<tr>
<td></td>
<td>Sean</td>
<td>Male</td>
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<td>22</td>
<td>73</td>
</tr>
<tr>
<td>Year 3</td>
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<td>Female</td>
<td>38</td>
<td>BME</td>
<td>12</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Sheila</td>
<td>Female</td>
<td>21</td>
<td>British</td>
<td>21</td>
<td>65</td>
</tr>
</tbody>
</table>

(Table 1: Participant information)

4.2 Data collection and analysis methods

The aim of the study was to gain insight into the student nurses’ experience of intercultural encounters in clinical placement. One-to-one semi-structured interviews were chosen as the data collection method since they allow the production of a large quantity of data, and bring insight into ‘what’ participants
perceive, and ‘why’ and ‘how’ these thoughts and feelings develop. In addition, the interview allowed the opportunity to clarify and ask any follow-up questions relevant to the research topic (Smith et al., 2009).

At the start of each interview, a consent form (appendix II) was signed and participants were reassured that the interviews would be confidential and anonymous. Interviews were recorded using a digital recorder. An interview protocol (appendix III), comprising open and closed questions, was devised and used as a prompt for the interview process. Every effort was made to ensure participants felt safe and comfortable, to establish a good rapport and to gain in-depth information. After the interview, key messages and experiences were noted down in a reflective diary.

Interview data were transcribed verbatim for analysis. Braun & Clarke’s (2006) six-step systemic thematic analysis process (Figure 1) was used to identify important descriptions of the phenomenon under study with the assistance of NVivo 10 software. After familiarisation with the data through reading and re-reading the transcripts, codes were generated in order to recognise patterns within the dataset related to the research question. The most important themes and supporting excerpts were then selected. This analysis process proved useful in developing a good understanding of the meaning underlying the data (Crist & Tanner, 2003).

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**Figure 1: Thematic analysis process (adapted from Braun & Clarke, 2006)**

- **Familiarise with data** (Read and re-read transcripts)
- **Generate initial codes** (Code data and name the codes)
- **Search for themes** (Transfer coded extracts to NVivo 10 according identified themes)
- **Produce the report** (Select & present the most important themes, with supportive excerpts)
- **Define and name themes** (Confirm the names of theme which suitable across cases)
- **Review themes** (Read all the collated extracts of each theme to identify patterns across cases)
4.3 Ethical considerations

Following ethical approvals from the participants’ university (appendix I) in May 2015, all students fitting the selection criteria received a formal invitation together with the ‘Participant Information Sheet’ (appendix IV), detailing the aims and process of the research. Informed consent was obtained before the interview was conducted (appendix II). In the process of reflecting on and interpreting participants’ experience in intercultural encounters, it is unavoidable that I may bring my own values, biases and worldviews (Bryman, 2012), due to my own complex experiences of intercultural encounters in healthcare services. Therefore, instead of attempting to eliminate my impact on the research, I remained reflective by acknowledging and disclosing my own views in a reflexive diary, and by being mindful of their influence throughout the study (Smith et al., 2009).

Whilst my lecturer status at the same institution as the participants enabled access, I was conscious that this power relationship may impact on students’ responses; thus, the subjectivity of the interpreted outcomes might be affected. Therefore, in order to minimise potential coercion, it was made clear at the information provision stage that I would not carry out any direct teaching or assessment of the participants (Cresswell, 2012). At the same time, interviewees were reassured that their participation would not be revealed to any other students or academic staff.
5. Findings

Large quantities of data were generated from interviews with four nursing students in this exploratory study. This section will present the key findings in relation to student nurses’ perceptions of intercultural competence, the challenges faced during their clinical placement (mainly focus on language barriers and negatively perceived relationships), and the relevant strategies employed in order to manage the situations, with supporting evidence.

5.1 Perception of intercultural competence

Based on the examples of intercultural encounters described by participants, it seems they consider ‘culture’ to be a mixture of country of origin and religion. Although both BME participants acknowledged that they frequently encountered British patients, they did not count these to be intercultural care encounters. For example, Afia said:

‘I have had intercultural encounters with people from various backgrounds. From Poland, Latvia, Malaysia, Africa. I haven’t met anybody from let’s say the Caribbean.’ (Afia, Year 3, from BME background)

The participants described intercultural competence as having knowledge and understanding of other cultures, and the ‘ability’ to adjust in order to meet the needs and have a smooth dialogue with cultural others. Sean and Afia articulated their understanding of intercultural competence as:

‘Intercultural competence is basically having the knowledge of the other cultures that are around you, knowing how you can adjust to that kind of culture and being able to work with anybody from a different culture… Also, it is the ability to be able to treat everyone as an individual and respect their rights and cultural aspects of their backgrounds.’ (Sean, year 1, from white British background)

‘It is being able to meet those people’s needs according to their level of understanding, so being able to communicate with them and to have a smooth dialogue with them.’ (Afia)

All participants valued the opportunity for exposure to diverse cultures in practice and commented on the benefits of these experiences:

‘It makes me think a lot more… trying to think ahead and thinking what they would want, what type of person they are, and trying to compromise that way.’ (Sheila, Year 3, from white British background)

‘My perception of intercultural care changed so much… I learned to understand it more and I think my knowledge of other cultures has increased.’ (Sean)
In addition, participants commented that their intercultural competence was also acquired informally, through previous work experience, which helped them to understand and develop different worldviews, as well as developing their confidence in dealing with intercultural situations in clinical practice. For example, Sean said:

‘In this particular case, everyone who was in the lab was French and my coordinator was an Italian and he worked for three Chinese professors. So there was a slight cultural barrier sometimes, like humour was a little bit different… At first I didn’t understand how that would affect individuals and like different people’s perspective on humour across different cultures, so I kind of learned about respect.’ (Sean)

White British students expressed more frustrations than students from BME backgrounds when facing intercultural obstacles. The latter emphasised how their own experiences of migration had helped them communicate in intercultural encounters:

‘I have developed that competence because my partner is white, my kids are mixed-race and I have lived in the white community areas throughout the eleven years… So I do understand their way of life and, I have even cultivated some of the habits - the way they speak, the way they wear their clothes and the way they eat… But that doesn’t mean that I get assimilated 100%, because my original background will still be there. That can never be taken away from me.’ (Bacchus, Year 1, from BME background)

5.2 Challenges in linguistic difficulties and students’ responses

One of the key challenges participants expressed they experienced was when a common verbal language with the patient was missing. They reported that a lack of shared language caused issues for both the patient (who found it difficult to convey their needs) and the student nurses (who were not able to explain procedures to the patients). Afia and Sheila said:

‘I see that it happens quite a lot though, with people of different minority backgrounds… this level of communication is not always straightforward… These barriers are more than the positive outcomes, really. For example, a gentleman from Latvia, so both of us have language barriers. We don’t understand a thing each other is saying. Because I didn’t always know what he wanted… Despite that, he would make certain gestures but I still didn’t understand what those mean…’ (Afia)

‘You can’t tell these patients [who don’t understand English language], and then they might not be compliant. It might be something that they really need, but they’re not going to take it. Or if they need any IVs, trying to stick a needle in someone’s arm when they don’t have a clue what you’re saying, it’s just not nice.’ (Sheila)
All participants considered that being able to communicate effectively with patients was one of the essential criteria to a satisfactory intercultural care encounter. Therefore, when participants were able to communicate with the patient, they were then satisfied with the outcome of the encounter. However, when basic communication was not established, participants expressed dissatisfaction with the nursing care they provided. This was illustrated most strongly by Afia, who said:

‘After I learned a few words of the patient’s language, I felt really good. It’s like I’ve crossed over into his world… I think this gentleman, he deserves the same as well, and language shouldn’t be something to prevent him from experiencing what the other patients had received…’ (Afia)

‘I feel disconnected from the care, really… Not being able to meet that need is like really not fulfilling the need of the person.’ (Afia)

‘For the gentleman from Latvia, he spent about three weeks there, in isolation, and on one of the occasions, the consultant and his team came around and they actually stood at his bed and they spoke what they had to say in English. He didn’t understand a word and then a decision was actually made at his bedside and I was thinking: well, what part does he have to play in there? It’s just like he’s not there at all. And the standards say “no decision about me without me”. So he was practically left out.’ (Afia)

‘The gentleman from Latvia, he didn’t know that he was going to be transferred to another hospital. The ambulance team, everybody knew, but he didn’t know. As the ambulance team showed up, he was just taken off the ward and transferred to another hospital... That’s very sad.’ (Afia)

Participants observed that staff responses towards communication difficulties varied greatly. Some staff were too anxious to interact with BME patients, since they did not know how to respond in such a way as to avoid causing offence. Sean said:

‘I’ve witnessed that some staff are a lot less likely to form a conversation with people from other cultures. So they won’t try and form a kind of dialogue or relationship. They’ll still give the same amount of care and they’ll still give all the information that is necessary, but they won’t necessarily try and form like a friendship … I think that these staff nurses and healthcare assistants may have a lack of understanding of that culture, so they didn’t know how to approach them, so there’s that kind of fear of the unknown.’ (Sean)

In order to overcome language difficulties, some participants accessed linguistic facilitators, including accredited interpreters, family members and healthcare professionals from BME backgrounds. They clearly valued the
importance of having accredited interpreters to facilitate communication, however, they had limited first-hand experience of communicating through an interpreter. Afia and Sheila commented:

‘For me, I definitely will get an interpreter in, because communication is very important. If they are stressed, or in pain, it’s very important to know that, because if I say “Look, I’m in pain and I need pain medication”, I will get pain medication. But if she says “I’m in pain” and I don’t understand, then how am I able to reduce the pain?’ (Afia)

‘…you try and communicate with pictures or hand gestures or things, if they’re still not understanding a clue of what you’re saying, generally try and get some sort of interpreter or family member in, so we can discuss what’s going on.’ (Sheila)

‘From what I’ve sort of experienced [accessing interpreters], a handful in three years.’ (Sheila)

They also commented that it was mainly the doctors who accessed interpreters’ services rather than nurses. Sheila commented that:

‘We had a Czech lady in who couldn’t speak any English and she needed consent for a procedure, so then we tried to get an interpreter in for that.’ (Sheila)

When asked them why accredited interpreters were not accessed for nursing practice, some of them provided reasons as:

‘There isn’t really a lot we could do, because we’d already asked for the interpreter and gone through all the forms and things and it was just waiting – but by the time we’d got one, they’d gone home, so it was a bit pointless.’ (Sheila)

‘I approached my mentor for interpreters. It’s not there… Whether it’s the organisational culture of not doing it or its financial cutbacks...’ (Afia)

Therefore, instead of using accredited interpreters, staff relied on patients’ relatives to assist communication, since it was felt that it was convenient and useful to identify the patient’s needs. Afia said:

‘Referring back to the gentlemen from Latvia, his niece came in… for her to get information that she actually needed on behalf of her uncle… she got some information that was helpful.’ (Afia)

However, participants also expressed their concerns of using family members as interpreters, such as lack of accuracy in translation, compromised patient confidentiality, and difficulties in their availability. Sean and Sheila said:
‘If the patient couldn’t have understood, you shouldn’t use family, because you are not sure exactly what information they are relaying and that they are not biased. So I felt in that particular scenario, perhaps the son may have said different things to the father, although from our point of view that’s not necessarily, it’s not to do with us because we are dealing with the mother, patient.’ (Sean)

‘She just had her granddaughter over in England; but she would only come occasionally and had a conversation with her and then ask us what was going on and then she would tell her grandma what was going on, but she wasn’t always available and trying to get an interpreter for her was really hard.’ (Sheila)

Apart from using relatives as interpreters, Sheila witnessed that a member of staff from a BME background was accessed as a temporary resolution to assist communication, with a positive effect. She said:

‘We had a Czech lady who couldn’t speak any English and she needed consenting for a procedure, so we tried to get an interpreter in for that, but luckily, there’s also a lady in the cath labs that speaks Czech, ‘cos that’s where she’s from, so we managed to get her up and sort of explain everything, which is great.’ (Sheila)

In order to overcome communication barriers, participants also described other approaches used in practice, including friendly body language, adjusted style of speaking, innovatively creating picture cards and using language apps on digital devices - even taking time to learn the patient’s language:

‘The next thing that actually happened was somebody actually took out their mobile phone and got the Polish app up and tried to get some words in, so that we can communicate with her.’ (Afia)

‘And so every time I took him to the toilet, he would say that word and then I realised that that’s thank you, so I would say it back to him and that made conversation a little bit easier; He was very cooperative after I’ve learned to say that word.’ (Afia)

‘We had to download pictures since there wasn’t anything available in the ward. We had to go through basic pictures, like drinks and toilet, and print off pictures.’ (Sheila)

‘So I actually rang my best friend, who I lived with, who’s fluent in German, and asked her key words, so like ‘toilet’, ‘pain’, ‘sitting’, ‘standing’, sort of basic words. I wrote them all down and photocopied them for the people who were in that bay.’ (Sheila)
5.3 Challenges in interpersonal difficulties and students’ responses

Both participants from the BME background perceived that they were isolated from their colleagues, undervalued and treated differently compared to their white British nursing student colleagues. For example:

’Sofifyouevenenterintoaconversation,nobodysterestsinterestedincommentingortalkingbacktoyous…It’sallaboutthefactthattheythinkyouareprobablynobody,oryoudon’tdeservetobethere.Youdon’tdeservetobeworkinginthatenvironment.Youcanonlyspeculatewhatpossiblymightbetherereason,inyecase,I’mnotheirkind’…’(Bacchus)

‘Interm stos,therearemymyselfandanotherstudentfromyearthreeonthisplacement,butonthe lastdayofplacement,asocialfarewellmeeting,gatheringwaskeptforher,buttawn’tincludedin it…”(Afia)

Such negative experiences have caused emotional distress and affected their learning in practice, which Bacchus and Afia articulated as follows:


‘Evenifyouwanttotalktosombodyand,byaskingquestions,thepersonistryingto answeryoubystillwalkingaway…Ifeellofitwoulddemeanyou.’(Bacchus)

When asked why they felt they were treated differently, Bacchus considered that it was his ‘physical colour’, since he did not feel there was any issue in his attitude and approach to learning and practice. Afia felt the same.

‘Yeah, I’m not of the same colour, so I’m not accepted in that group, and I think that is the problem. Because I am different… perhaps as a result of my physical colour, and that is really not accepted. Because if it is work ethics, probably we work better than them. If it is respect, we give more respect than them. If it is any kind of thing that can be assessed, we do well. So I don’t see where the problem is other than the fact that, physically looking, you are a different person and the fact that you are different, you are not accepted.’ (Bacchus)
The BME participants’ responses to this were quite drastic: Bacchus stated that he wished he could paint his skin colour ‘white’ in order to be accepted, whilst Afia had considered leaving the course.

‘If I could change my colour, paint my colour white and then go to a different ward on a different placement, my experience would be different. I wish I could do that...’ (Bacchus)

‘...there are so many times when I considered leaving [the course].’ (Afia)

Both Afia and Bacchus expressed their passion to be a nurse. Therefore, in order to survive and continue on the nursing programme, they emphasised the value of resilience and willpower, and articulated this as follows:

‘It’s all about the resilience keeping me going... I promise myself I will get registered and I will be one of the best nurses.’ (Bacchus)

‘I was thinking whether [I had] chosen the wrong profession... So, so many times... I think it’s a lot of willpower and resilience and just keeping focused as to why I want to do this [to become a nurse] that actually kept me here in nursing, so willpower is a strong tool for me, really.’ (Afia)

They also commented on other strategies, such as setting realistic goals and sharing their experience with peers from BME backgrounds, family, clinical staff and academics, with positive outcomes:

‘I’m learning how things are being approached and things can be watered down... And at the same time, I don’t want to make a mountain out of something that I can probably share some care and compassion on.’ (Afia)

‘I felt that to open up was the best way. Initially, I thought that wasn’t the case, because I felt that if I reported to the university what was going on to the staff, I probably would make the situation worse.’ (Bacchus)

‘You’ve got to accept the fact that, you can’t change people’s behaviour overnight and so these are the people you’re going to work with, so you have to find a way of coping with them and seeing how you can work around it.’ (Bacchus)
6. Discussion

On their systematic review of culturally competent healthcare system, Anderson et al. (2003) reveal that a culturally competent setting should have a mix of diversified staff recruitment and retention, interpreting service, and intercultural material and training provision. This section will discuss student nurses’ perceptions of intercultural competence, challenges faced in terms of linguistic difficulties, perceived discrimination they encountered during clinical placement, and strategies employed to deal with these situations.

6.1 Intercultural competence

Participants in this pilot study perceived intercultural competence as the mix of the knowledge to understand diverse cultural needs, and the ability to adjust behaviour and attitudes in order to establish smooth dialogue with patients and to provide equal standards of care to patients from BME backgrounds. This definition is similar to Leininger's (2002) articulation, which describes competent intercultural care as flexibly providing relevant and appropriate care to clients from diverse ethnic and cultural backgrounds. This shows that the student nurses have a good conceptual understanding of competent intercultural care.

Student nurses, including those from BME communities, all view intercultural care encounters as situations which involve interactions with patients from a BME background. This may be due to student nurses equating it with a common shared spoken language. Student nurses from BME backgrounds spoke fluent English, and therefore did not perceive their communication with white British patients as intercultural. This finding is consistent with studies on the experience of international nurses in the workplace (Allan & Larsen, 2003; Gerrish & Griffith, 2004).

Participants commented that their intercultural communication skills were mainly acquired from previous work and life events, and these were
transferred to placements when appropriate. Student nurses from BME groups commented that their migration experience had helped them empathise with the difficulties faced by BME patients (and their families) in healthcare. In terms of a formal intercultural education at university, participants felt that it was there, yet was rather brief and did not make a lasting impression, therefore they expressed a desire for more, including different cultural beliefs and lifestyles, religious practice, and the epidemiology of various diseases in different populations. Feng et al. (2009) suggest that having ‘depth’ concepts embodied in education (such as understanding and meaning), and blending them with ‘surface’ notions of experiential learning, would be a useful strategy for students to become intercultural practitioners. Therefore, encouraging students’ active exposure to intercultural encounters in practice and facilitating an open discussion of such experiences in conjunction with a formal systematic intercultural programme at university, could be a way forward.

6.2 Challenges of lack of shared language in communication

All student nurses who participated this exploratory study reported that effective intercultural communication was important for quality nursing care and to their own satisfaction of intercultural encounters (ICE). Their success of ICE was described as mutually positive feelings about intercultural relationship, task achievement and stress minimization. This is consistent with Deardorff (2009) theory of successful ICE outcomes.

This study revealed a number of challenges participants encountered when communicating with patients who did not speak English. Without a shared language, patients were not able to express their needs to the nurse. Consequently, it was difficult for the student nurse to understand, and therefore very difficult to provide appropriate care to meet the needs of the patient. On the other hand, the lack of a shared language caused limited information to be passed on to the patients, in order for them to understand what had happened and why, for example. Such an insufficient information exchange situation leads to poor-quality nursing care. One participant
expressed her sympathy and sadness when she witnessed a patient’s condition being discussed and a decision made by the medical team without the patient’s involvement. Another stated that a patient was transferred to another city without the patient’s knowledge. This shows that basic healthcare communication was lacking, implying that more intercultural communication training is needed across healthcare professions.

Student nurses in the current study perceived that staff (including both qualified staff and support workers) were anxious about interacting with those from other cultures, and feared making mistakes due to a lack of confidence and knowledge in communication with these patients. This could result in accusations of insensitivity to patients from different cultural backgrounds (Arakelian, 2009). This indicates a lack in understanding of diverse cultural situations and a requirement for intercultural skills development, to facilitate interacting with cultural ‘others’ effectively. Therefore, further training is needed to develop staff awareness, sensitivity and competence in intercultural care.

6.3 Verbal communication facilitators

Student nurses recognised the value of having professionally trained interpreters available to facilitate intercultural communication. However, the findings revealed that qualified nurses rarely use accredited interpreters. Reasons for this include: non-availability, long waiting times, cancelled appointments, financial constraints, and staff members’ lack of proactivity to access interpreters. This is consistent with other research (Flores, 2005; Gerrish et al., 2004).

The amount of time spent waiting for the interpreter to arrive was another issue. One participant was disappointed with the interpreter service, reporting that their patient was already discharged by the time the interpreter eventually arrived. This shows the need for more efficient administration of the service, either by employing more accredited interpreters, or by using alternative interpreting facilities, such as telephone or internet services (Flores, 2005).
Another participant pointed out that an interpreter with whom he had worked had little knowledge about healthcare - the participant thus had to spend ‘a lot of time’ explaining basic medical procedures, and was still concerned about the accuracy of information translated to the patient. Therefore, in order to improve the quality of the interpreting service, there is a demand to further develop interpreters’ essential healthcare knowledge and to increase the accessibility and availability of accredited interpreters in practice. One student also highlighted a lack of proactivity by staff where language barriers were encountered. This suggests that health professionals training to increase their awareness of the importance of using interpreters is needed.

For the above reasons, the findings revealed that family members are preferred to professional interpreters for patients who require language support. This finding concurs with the Anderson’s study (2003), which reported only 12% interpreters were used to facilitate communication; in contrast to 88% linguistic facilitators being family members, or ad hoc hospital staff. Although this may be a convenient way of dealing with communication obstacles, participants expressed several concerns about this approach. For example, despite relatives being able to make social conversations in English, they lack knowledge of medical terminology and subsequently they may not understand English in relation to complex medical concepts and procedures (Flores, 2005). This may also lead to inaccurate patient’s medical history taken, with the risk of inappropriate interpretation and intervention (Campinha-Bacote, 2002). Additionally, participants were also worried about the use of relatives to translate, as this can cause issues of confidentiality. Furthermore, some family members may have work or other commitments which could impact on their availability. This was reported on other study (Jirwe et al., 2010) It is therefore important that student nurses and qualified staff are aware of the potential problems when using family members as interpreters; and they should offer patients the choice.

Staff from the same BME background, with the same language as the patient, were reported as successfully interpreting surgical procedures in this study. The participant who reported this also showed high satisfaction with the
intercultural communication and suggested that it would be beneficial to have more bilingual or multilingual staff. This finding also echoed Flores’ (2005) study which reported the value of bilingual healthcare providers to BME patients in terms of satisfaction, quality of care and optimal communication. Therefore, it is suggested that a record is kept of staff members’ language proficiencies during the recruitment process, with the choice given on whether they would like to help in situations when an urgent interpreting service is needed. Universities could consider providing language lessons for student nurses who are interested in learning a new language.

6.4 Non-verbal communication aids

In order to facilitate intercultural communication, numerous non-verbal aids were used, including friendly and respectful body language (such as appropriate eye contact and sensitivity to personal space) (Leininger, 2002), picture cards, vocabulary booklets for daily care, as well as information technology, such as the use of translation apps. This was reported to have made a positive impact on communication when assessing and providing nursing care to patients with language difficulties - especially when interpreter services were not available. These student nurses also took the initiative and even made attempts to learn the patients’ language in order to cross the language barrier, demonstrating their warm care and compassion towards their patients (NMC, 2015). Consequently, the participants reported that patients became more cooperative and more satisfied with the care provided (Deardorff, 2009).

Student nurses from a white British background found it particularly frustrating when the patient did not speak English. However, nursing students from BME backgrounds seemed have higher confidence in their ability to employ other strategies to break communication barriers. This possibly results from their previous life experiences of dealing with communication difficulties when their English was not necessarily fluent (Jirwe et al., 2010).
6.5 Discrimination

Despite white British students show more frustration than their BME counterparts in the face of linguistic obstacles, the latter reported more emotional suffering, such as social isolation, discrimination and depression, in placements.

It is recognised that staff and students’ intercultural competence is critical to high morale and teamwork in the workplace. In their research on overseas nurses’ experiences of discrimination at work, Allan et al. (2009) identified two forms of discrimination within clinical workplaces: overt discrimination and indirect discrimination. Overt discrimination is described as ‘open racism, xenophobia and deliberately excluding or harming staff from different cultural backgrounds’; whilst indirect discrimination is ‘rooted in the power relations inherent within social structures and may therefore be unintentional, conscious or unconscious, harm or exclusion of cultural others’ (Allan et al., 2009, p. 900), therefore the latter is harder to notice. When student nurses are not supported in the way their white British peers are, and are deliberately or unintentionally excluded from communication and learning, they feel less valued, and more isolated and frustrated. Such negative experiences can undermine BME student nurses’ morale, self-esteem and confidence, and consequently might lead to depression and the requirement for counselling treatment (Allan et al., 2009). Therefore, there is an urgent need for further staff (qualified and unqualified) to take intercultural training, in order to raise their awareness of the vulnerability of student nurses from BME backgrounds, and to establish and maintain culturally sensitive and supportive environments for their learning and wellbeing (Stevenson & Rao, 2014).

It was widely reported that acculturating into a new environment - such as a placement - is not only time-consuming, but also difficult for student nurses (Chesser-Smyth, 2005). Negative perceived relationships and social isolation increase the stresses experienced by those students involved. Student nurses from BME backgrounds commented that their experience of discrimination
has often caused them to consider leaving the nursing course, even at the final stage of their training. In order for them to survive and thrive despite adverse work relationships with their mentors and other staff, they highlighted the value of resilience, which was mainly gained from life experience, when dealing with stressful situations in placements. Jackson et al. (2007) refer to resilience as an active process of shifting balance between vulnerability and the ability to adjust to adverse situations and maintain emotional equilibrium to get some sense of control to their environment, which will help them to move on in a positive manner. This suggests that developing personal resilience is a useful strategy to reduce vulnerability in workplace situations, so it should be supported and encouraged from the early stages of training (Harvey et al., 2006).

In addition to resilience and willpower, participants also reported the benefits of accessing support and encouragement from family and peers from BME backgrounds. This helped to eliminate their need and/or desire for formal support services outside of their international network (Abriam-Yago et al., 1999). Both participants hesitated to disclose their negative experiences since they were worried about whether this would detrimentally affect their situation and make them more vulnerable. However, ultimately they did find discussion of their emotional suffering with mentors and academics a useful strategy. Therefore, they expressed their longing for staff who are caring, understanding and respectful to cultural others. This is consistent with the literature about the experience of overseas trained nurses’ experience in the UK (Larsen, 2006) and American nursing students, for whom English was a second language (Abriam-Yago et al., 1999; Klisch, 2000).
7. Conclusion

This section will outline the key findings, acknowledgements of limitations and contributions, recommendations from the project and suggestions for future research.

7.1 Key findings

This study explored first- and final-year student nurses’ experience in intercultural encounters during clinical placement. The findings from the study show that nursing students have a good conceptual understanding of intercultural competence, and are willing to further develop their intercultural knowledge and communication skills. When a shared language is lacking, student nurses described their concerns about the quality of care they delivered due to difficulties in explaining technical procedures to the patients as well as understanding their needs. A variety of verbal and non-verbal approaches were employed to overcome these challenges, with some positive outcomes.

Even though the participants all appreciated the importance of accessing accredited interpreter services, the findings also revealed that the service gatekeepers (the qualified nurses) seemed not to use the interpreters sufficiently due to financial constraints, long waiting times and also a lack of interest. Therefore, the relatives of patients were the most popular facilitators for communication with patients with language barriers. Bilingual health professionals were praised for their temporary resolutions for patients when neither accredited interpreters nor family interpreters were available.

Overall, students from BME backgrounds perceived that they were viewed very negatively by colleagues in their placements. This resulted in high levels of stress. Such negative experiences made them feel unvalued, doubted, emotionally hurt and, in some cases, they even considered leaving the course. It required strong will and resilience for them to stay on the programme.
7.2 Limitations & Contributions

This project is the preliminary exploratory work within the early part of a doctoral study, to test the research methodology and methods involved in exploring student nurses’ experiences of intercultural encounters in clinical practice. The small number of participants from only one higher educational institution indicates that caution needs to be taken with conclusions based on this study. The student nurses who participated in the current study may have different intercultural experience to students from other ethnic backgrounds due to their age, country of origin, years of living experience in the UK, and level of English. Furthermore, it is also acknowledged that the participants’ placement experience and intercultural care education programme may be different from healthcare settings and universities elsewhere in the country, where BME populations are different (ONS, 2013). However, many of the findings are echoed in the literature regarding the difficulties nurses encountered when a shared language is missing, the range of initiatives and strategies used to break the language barriers, staff attitudes towards interpreter services and the desired interpersonal attributes of interculturally competent staff (Abriam-Yago et al., 1999; Flores, 2005; Gerrish et al., 2004; Jirwe et al., 2010).

Recognising the above limitations, the findings bring three new insights: first, the present study explores student nurses’ experiences in clinical intercultural encounters, which adds to existing knowledge, mainly from qualified nurses’ and patients’ perspectives; second, it establishes differences in perspectives between BME students and their white British counterparts when encountering difficulties in communication with patients (for example, the latter tend to be more frustrated than students from BME backgrounds); finally, it reveals the vulnerability of BME student nurses in placement when interacting with multidisciplinary teams and highlights the importance of resilience and other positive approaches (such as accessing support from peers, clinical staff and academics) when discrimination and prejudice are encountered. Combined with increased intercultural support from mentors and academics, this helped these students to reach their professional and academic goals.
7.3 Recommendations

The recommendations from this project are of relevance to service providers and managers, university academics and accredited interpreter services.

Service providers and managers:

- To provide further training to develop staff (both qualified and support workers) awareness, sensitivity and competence in intercultural care.

- To address the importance of accredited interpreters and encourage the use of a variety of interpreting facilities, such as telephone and internet services.

- To have a picture booklet (with or without simple multilingual vocabulary) at every ward, or at least downloadable on the hospital intranet, to allow easy access for staff and student nurses who care for patients requiring linguistic support.

- To have modern technological devices with linguistic apps readily available on wards for patients who require support.

- To provide a choice for patients, as to whether they would like to have their relatives as interpreters.

- To keep a record of staff members’ multilingual proficiencies during the recruitment process, with the choice of whether they would like to help in situations when an urgent interpreting service is needed.

- To raise intercultural awareness of the vulnerability of student nurses from BME backgrounds and promote sensitive working approaches by qualified professionals and support workers.

- To establish and maintain a welcoming and supportive clinical learning environment that supports the learning and wellbeing of BME students.
University and academics:

- To provide resilience discussions and formal training from an early stage of student nurse training.
- To invite former patients and staff from BME backgrounds to talk about their intercultural care experience in clinical settings. This would contribute to raising student nurse awareness of intercultural communication issues.
- To include more cultural related information and discussion in pre-registration nursing curriculum, such as cultural beliefs, religious practice, and epidemiology of various diseases in different population.
- To encourage nursing students to share and exchange experiences of intercultural care and intercultural encounters during placement and within the study period.
- To encourage students from BME backgrounds to disclose and discuss with their mentors and university staff unfair treatment (from qualified and unqualified staff) while on clinical placements.
- To investigate, liaise and take action with placement managers when BME student nurses encounter discrimination and racism on placement.

Accredited interpreter service:

- To provide further healthcare knowledge training in order to develop the competence of existing interpreters.
- To increase the accessibility and availability of accredited interpreters in order to meet linguistic support needs in clinical practice.

7.4 Suggestions for future research

Despite participants in this study having articulated their understanding of intercultural care competence, it would be useful to observe how they apply this knowledge and understanding into practice during intercultural encounters, and to explore whether there is any difference in their attitudes
and approaches to cultural others between the first year and final year of the study. Also, it will be useful to see if the findings are transferable to nursing students in the wider population (such as a different cohort, different BME student groups and different nursing branches), and in other healthcare programmes at different universities and healthcare settings. In addition, it would be interesting to interview qualified staff, academics and patients about their views of working with BME students, and their views of interpreter services for patients who require linguistic support.
8. Abbreviation and Glossary

8.1 Abbreviations

BME: Black and Minority Ethnics

BSc (Hons): Bachelor of Science (Honours degree)

CPHVA: Community Practitioners and Health Visitors Association

DH: Department of Health

FHEA: Fellow of Higher Education Academy

HEE: Health Education England

ICC: Intercultural competence

ICE: Intercultural encounter

MSA: Mary Seacole Award

MSc: Master of Science

NHS: National Health Service

NMC: Nursing & Midwifery Council

ONS: Office of National Statistics

PGDE: Postgraduate Diploma in Education

RCN: Royal College of Nursing

RGN: Registered General Nurse

RNT: Registered Nurse Tutor (by NMC)

UK: United Kingdom

UNISON: Europe’s largest public service union and one of the largest trade unions in UK represent staff who provide public service both in public and private sectors
8.2 Definitions of key terms

**Culture**: the shared beliefs, values, ideas, language, communication and norms of a group of people. Whilst **cross-culture** is defined a static ‘in-between’ position when encounter different culture to one’s own, **Interculture** means an interactive process among these positions.

**Competence**: not only a list of skills which are applied in a given context, but a combination of attitudes, knowledge, understanding and skills applied through action in any relevant situation. Intercultural care encounter is one such situation.

**Discrimination**: the unjust or prejudicial treatment to people who are different on the ground of race, age or gender. There are two types: overt discrimination and indirect discrimination. **Overt discrimination** is described as open racism, xenophobia and obviously deliberate strategies to exclude or harm staff from different cultural backgrounds. **Indirect discrimination** is rooted in the power relations inherent within social structures and therefore may be unintentional, conscious or unconscious, harm or exclusion of cultural others.

**Ethnocentrism** is judging another culture purely by the values and standards of one’s own, and the belief of superiority in one’s personal ethnic group. **Ethnocentric individuals** believe that they are better than other individuals for reasons based solely on their heritage.

**Intercultural Awareness**: the capacity for self-examination and in-depth exploration of one’s own cultural background as well as others. This process involves the recognition of one’s biases, prejudices, and assumptions about individuals who are different.

**Intercultural Care**: provision of care which is relevant and appropriate for individuals and groups from diverse ethnic and cultural backgrounds.

**Intercultural Communication**: a mutual information-exchanging process; therefore, to be effective, it requires an open and understanding attitude.
towards people who have a different background and language to themselves. This is one of the essential parts of intercultural skills.

**Intercultural Competence:** the capacity to respond successfully to cross-culture situations that present tasks, difficulties, challenges or opportunities for the individual - either singly, or together with others. The components of intercultural competence may be broken down into attitudes, knowledge and understanding, skills and actions and applications.

**Intercultural Encounter:** an encounter with another person (or group of people) perceived to have different cultural affiliations or background from student nurses during their placement period. **Intercultural care encounter** is a situation when student nurses interact with patients whose cultural background is different to their own.

**Intercultural Knowledge:** includes different health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Obtaining cultural knowledge helps healthcare practitioners understand the diverse worldview which guides patients' thinking, doing and being.

**Intercultural Sensitivity:** the ability to recognise relevant cultural differences and interact with cultural others accordingly in order to meet the diverse healthcare needs.

**Interculture:** is not simply a static ‘in-between’ position when encounter different culture to one’s own, but an interactive process among these positions.

**Racism:** the belief that all members of each race possess characteristics, abilities, or qualities specific to that race, which is then used to distinguish it as inferior or superior to another race or races.

**Resilience:** an active process of shifting balance between vulnerability and the ability to adjust to adverse situations and maintain emotional equilibrium to get some sense of control over the environment, which will help student nurses to move on in a positive manner.
9. References


Appendix I

Ethical Approval

from

Participants’ University Ethics Committee
Joy Shao  
Department of Healthcare

22 May 2015

Dear Joy

Faculty of Health and Life Sciences Research Ethics Review DHCShao190315  
Title: An Exploratory Study of Pre-Registration Nursing Students’ Lived Experience of Intercultural Encounters in Clinical Practice

Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:  
http://www.northumbria.ac.uk/researchandconsultancy/ethgov/policies/?view=Standard

All researchers must also notify this office of the following:  
• Commencement of the study;  
• Actual completion date of the study;  
• Any significant changes to the study design;  
• Any incidents which have an adverse effect on participants, researchers or study outcomes;  
• Any suspension or abandonment of the study;  
• All funding, awards and grants pertaining to this study, whether commercial or non-commercial;  
• All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

Ethics Lead for Healthcare, on behalf of the Faculty Research Ethics Review Panel
Appendix II

Participant Consent Form
Participant Consent Form

PARTICIPANT IDENTIFICATION NUMBER □□□□

STUDY TITLE: An Exploratory Study of Pre-registration Nursing Students’ Lived Experience of Intercultural Encounters in Clinical Practice

NAME OF RESEARCHER: Mrs Chun Hua Shao (Joy)

Please read carefully the “Participant Information Sheet” before completing this consent form. Please indicate whether or not you agree to take part by initialing the appropriate box, and signing the form at the bottom.

Please initial the boxes

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I have been informed that the investigator can be contacted via email j.shao@northumbria.ac.uk or telephone 0191 215 6784.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my rights of being as a student in University or legal rights being affected. I understand that all data will be destroyed if I withdraw.

3. I understand that any data collected from me will be anonymised, and my personal details will be kept confidential.

4. I am willing to participate in an interview. I agree to be contacted by the researcher and therefore provide my contact details on the invitation sheet.

5. I agree to audio record the interview the study in which I take part for the purposes of the research. I understand that I may ask for the recording to be stopped at any time. I understand that the recordings will be kept safely and then discarded seven years after the study is completed.

6. I agree to the use of extracts and results from the study in the researcher’s doctoral thesis, publication of journal articles, conference presentations and local seminars.

7. I would like to take part in the above study.

Any concerns about this study, please addressed to:

Sheena Smith, the Ethics Sub-Committee of the School of Education University, on or e-mail: Sheena.Smith@Durham.ac.uk; Coordinator of Dept of Healthcare University, on or email: and Research Supervisor on or email: ; and Research Supervisor.

Name of Participant _____________ Date______ Signature_______________

I certify that I have presented the above information to the participant and secured his or her consent.

Name of the Researcher_________ Date________ Signature_________________
Appendix III

Interview Protocol
Interview Protocol

STUDY TITLE: An Exploratory Study of Pre-registration Nursing Students' Lived Experience of Intercultural Encounters in Clinical Practice

NAME OF RESEARCHER: Mrs Chun Hua Shao (Joy)

PARTICIPANT IDENTIFICATION NUMBER: ____________________________

1. Welcome & Introduction:
   - Introduce self
   - Brief overall aim and purpose of the project
   - Reassure confidentiality and anonymity to research
   - Take consent to audio recording and participation of the study

2. Social & Cultural Background:
   e.g.
   - ‘Where were you born?’ ‘Where did you grow up?’
   - ‘Would you like to tell me about any experiences you had with people whose cultural background was different to you before your entered the course?’

3. Student’s Intercultural Experience in Practice:
   e.g.
   - ‘Can you tell me your experience of working with other cultural background during placement?’
   - ‘What does culturally competent care mean to you?’
   - ‘How confident in delivering culturally competent care?’
   - ‘How did you acquire your knowledge and skills in cultural competent care?’
   - ‘Are there any barriers to providing individualized care to patient? How?’
   - ‘What do you think is required to support you in providing culturally competent care? Why?’
   - ‘Are there any topics which you think should be addressed in student’s training? Why?’
   Prompts might be used: e.g. ‘What did you do then, and why? ’‘How did you feel at the time and why?’

4. Closing Comments & Thanks:
   e.g.
   - ‘Is there anything else you’d like to tell me?’
   - ‘Do you have any questions for me?’
   Express thanks for their participation, give information should any follow-up support needed, and ask if they would like to receive a summary of the results when available (if so, how? Email/post)
Appendix IV

Participant Information Sheet
Participant Information Sheet

Study title: An Exploratory Study of Nursing Students’ Lived Experience of Intercultural Encounters in Clinical Practice

Dear student

I am undertaking the study of exploring Pre-registration nursing students’ experience in working with people whose culture backgrounds are different to themselves during their clinical placement periods. You are warmly invited to take part in this study. Please take time to read the following information carefully and discuss it with others if you wish. Also, please feel free to ask me if there is anything that is not clear or if you would like more information before agreeing to be in the study. Thank you.

What is the background and purpose of the study?

The UK 2011 Censuses indicates a significant increase in the figures of people from Black and Minority Ethic (BAME) groups. There are those amongst this group who have different healthcare delivery needs from those of the indigenous people due to their diverse cultural needs and religious beliefs. Promoting equality and equity has been at the heart of NHS England’s values to ensure that the organization exercises (including staff recruitment and service provision) fairness in all that it does and that no community or group is left behind in the improvements that will be made to health outcomes across the country. The purpose of the study is to explore Pre-registration nursing students’ experiences in intercultural communication and interactions during clinical placement periods.

Why have I been invited?

You have been invited to take part in this study because you are recognised as one of the Pre-registration nursing students who is likely to encounter intercultural communication and interactions during your study at Northumbria University.

Your views are important for the study because your experience of this topic can help educators have a better understanding in nursing students’ intercultural experience, and consequently help them tailor experiences to promote and further enhance student nurses’ intercultural competence in clinical practice.

Do I have to take part?

Taking part in this study is voluntary. It is up to you to decide whether or not to take part. You can ask me any questions you want to in order to understand what is involved in the study and what this would mean for you. If you would prefer not to take part, you do not have to give any reason and no one will mind.

If you agree to take part you will be asked to sign the consent form to say that you are taking part voluntarily and that you understand what is being asked of you. Even if you sign a consent form, you are free to withdraw from the study at any time.
What will happen if I take part?
I will invite you to talk about your views of working with people whose cultural background
are different to yours during your placement periods and its impact on your clinical
experience. This one to one face to face interview will be held in a private room at ___________
Campus or a public place at the choice of you, and at a time which is convenient to
you. With your permission, I will record the interview with a small digital audio recorder. The
interview will last about 60-90 minutes.

What are the possible benefits of taking part?
Taking part in this research project will give you opportunity to see how qualitative research
is undertaken. You will also be able to record in your Personal and Professional
Development Portfolio (PPDF) that you have participated in a research project as part of
your on-going development. As a result of participating in this study, you may also develop a
more heightened awareness of intercultural communication with other staff and patients in
healthcare settings. Also, the research outcomes will also inform intercultural education for
the pre-registration nursing curriculum in the future. If you wish, you may receive a copy of
the summary report of the study.

Will my taking part in this study be kept confidential?
All information collected during the study will be kept strictly confidential. Any information
about you will have your name and address removed so that you cannot be identified from it.
The data for this study will be collected using a digital audio recorder during the interview.
Once the interview has ended, the recorder will be kept in a lockable briefcase and
transported from the interview venue to my locked office at __________ Campus. The
recording will then be transcribed and a written record of your discussions will be created.
These documents will be anonymised and marked by a unique identified codes allocated to
you by me. This will not be seen by anyone else.

The research data generated from the interviews will be kept securely on a password
protected computer and in a locked cabinet, accessible only to me. There is onsite security
and alarms are fitted to the building. All digital recordings will be deleted and any paper
based information will be shredded seven years after the study is completed according the
university Data Protection policy, which is based on Data Protection Act 1998 and Freedom
of Information Act 2000.

If I take part, can I withdraw from the study at a later date?
You can withdraw from the study at any time. Simply contact me that you would like to
withdraw. All data collected from you will be destroyed as confidential waste unless you
agreed to use the data up until the date and point of withdrawal. My contact details are at the
end of this information sheet.

Who has reviewed this study?
The proposed study has received ethical approval from the School of Education Ethics Sub-
Committee at __________ University where I registered for doctoral studies, and the Faculty
Research Ethics Committee at __________ University where the research is to take place.
What will happen to the results of the research study?

The findings from the initial phase of the study will be reported to the Mary Seacole Award Committee and disseminated at Mary Seacole Award Ceremony at Headquarter of Royal College of Nursing. A further detailed research report will be written as part of my doctoral thesis and will be shared with the Pre-registration Nursing programs at Faculty of Health and Life Sciences. The results will also be published in education and health care journals and conferences. With your permission, anonymous quotes may be used to illustrate the study’s findings. You will not be identified in any report or publication arising from the study. If you wish, you may receive a copy of the summary report of the study.

What if I have questions or concerns after reading this sheet?

In case of any further questions about any aspect of this study, please do not hesitate to contact me in the first instance, and I will do my best to clarify or address these. If you have any concerns about this study, please contact my supervisor, Dr Prue Holmes at Durham University on 01913348354 or email p.m.holmes@durham.ac.uk.

What should I do now?

If you think that you would like to take part in the study, please sign and return the attached invitation sheet to my office at [insert address] or send through your University email to j.shao@northumbria.ac.uk. On receipt of the return sheet/email, I will contact you to arrange the interview at mutually convenient time at a mutual convenient place.

Thank you very much for taking the time to consider taking part in the study.

Chun Hua Shao (Joy)

Telephone: 0191 215 6784
Email: j.shao@northumbria.ac.uk