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TITLE:

Nurse educators' understanding of cultural humility and their perspectives on its potential to enhance student nurse's delivery of culturally responsive and sensitive care.

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A thesis submitted in partial fulfilment of the requirements of Glasgow University for the degree of Doctor of Education

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Abstract

The evolving demographic landscape in Ireland has driven healthcare reforms to incorporate an intercultural approach that meets the needs of increasingly culturally diverse communities. Nursing faculties and educators are mandated to include more diversity, equality, and inclusion (DEI) into their nursing programs, thereby proactively responding to local, national, and global needs.

This study examines nurse educators' understanding of cultural humility and its potential to enhance student nurses' delivery of culturally responsive and sensitive care. The study is grounded in the theoretical framework of cultural humility, an approach that emphasises reflection, self-awareness, openness, and a lifelong commitment to understanding and respecting diverse cultures. This provides a framework for exploring how nurse educators integrate cultural diversity into their educational practice, and for assessing the potential of alternative pedagogies, specifically those embracing the principles of cultural humility in the practice of cultural diversity in nurse education.

The research utilises a qualitative approach, adopting an interpretive/constructivist paradigm to reflect the epistemological aims of the study. This study utilises a purposive sampling by interviewing ten nurse educators currently teaching in a BSc Nursing Programme at one University in the Republic of Ireland. The data were collected using two methodologies, vignettes and semi-structured interviews. A reflexive thematic analysis approach was employed to analyse the data.

The findings indicate that nurse educators play a crucial role in preparing future nurses for culturally sensitive care, but there is a recognition of limitations in current practices. The study suggests a need for more focused, standardized, and collaborative approaches to cultural diversity in nurse education. The findings suggest that nurse educators have a positive outlook towards the integration of cultural humility, and they see this as a potentially valuable tool for enhancing responsive and sensitive care for diverse patients. The research findings have clear implications for curriculum development and establishment of inclusive practices in nurse education. These outcomes can enable nurse educators to better prepare future nurses for the challenges of providing culturally sensitive care in diverse healthcare settings.

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Candidate's Declaration

I certify that this material, which I now submit for assessment on the program of study leading to the award of the degree of Doctor of Education, is entirely my own work. I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save, and to the extent that, such work has been cited and acknowledged within the text of my work and references.

Signed:

Chapter One Setting the Scene

1.1 Introduction

This chapter provides the contextual background for my dissertation, outlining my personal and professional interests that were key drivers in the research. Although the primary focus of the study is nurse education, insights from nursing clinical practice and other associated disciplines will be considered. Furthermore, the chapter offers background information on the current status of cultural diversity in nursing education and outlines the dissertation's overall structure.

1.2 Research Introduction and Background

This study examines nurse educators' understanding of cultural humility and its potential for educating student nurses to deliver culturally responsive and sensitive care in diverse healthcare systems. Examining current approaches to cultural diversity in nurse education, valuable insights can be gained which contribute to the development of new educational pedagogies and approaches that will strengthen its practice. Cultural humility is gaining traction in healthcare education as a valuable tool to equip educators with lifelong skills of self- reflection and self-evaluation. This enables them to develop interpersonal sensitivity, openness, and inclusivity in their approaches to teaching students (Solchanyk et al., 2021). It also involves challenging power imbalances and stereotypes while fostering an appreciation of cultural differences (Tervalon & Murray-García, 1998; Danso, 2018; Smith & Foronda, 2021; Foronda et al., 2016; Fisher-Borne et al., 2015; Yeager & Bauer-Wu, 2013). Using cultural humility as an approach provides a new dynamic in the patient-practitioner relationship, promoting person-centred care that is respectful of the patient's cultural diversity and viewpoints (Lekas et al., 2020). Foronda et al. (2016, p. 1) suggest that nurse education needs to move 'beyond communication techniques to address the broader related constructs of patient safety, valuing diversity, team science, and cultural humility'. Nurse educators can enhance inclusivity practices by adopting culturally sensitive pedagogies and inclusive teaching methods. Additionally, this study can contribute to a deeper understanding and consideration of cultural diversity in nurse education, fostering a more inclusive and culturally aware healthcare environment.

As part of the European Union, Ireland has become a society characterised by increasing cultural and ethnic diversity. The significant changes to global migration have resulted in growing diversification in patient populations worldwide (Markey, 2020), but continued deficits in caring for diverse patients are still reported (Almutairi et al., 2017). Although Ireland is home to half a million individuals from various nationalities (CSO, 2023), there is a concerning lack of knowledge about aspects of cultural diversity in Irish healthcare systems. This has prompted the Irish Health Service Executive (HSE) to explore strategies that will address the challenges of

managing ethnocultural diversity when caring for a diverse demographic of patients (HSE, 2018). These initiatives signify a shift in health care policies, designed to promote and adopt caring practices which respond sensitively to a broadening, culturally diverse patient population in Ireland. They also emphasise the existing challenges in delivering culturally responsive and sensitive care and in promoting inclusivity in current healthcare systems. Such reports have implications for all disciplines in healthcare, but for nurse educators, these reports emphasise the need to adapt their practices to support the integration of pedagogical approaches, improving the preparation of student nurses serving diverse communities. The inclusion of approaches that respond to cultural diversity in healthcare education can empower practitioners to transform systems that can interact with the health beliefs, needs, and behaviours of their diverse patients (Betancourt et al., 2003).

1.3 Considering Cultural Diversity in Nurse Education

The nursing profession has emphasised the need for nurse educators to focus on preparing students to care for diverse communities (AACN, 2017; NLN, 2017). Persistent reports of significant challenges in the provision of care to diverse patients have led to renewed calls for nurse educators to prioritise the instruction of culturally sensitive care for diverse patients (Cox et al., 2023: Almutairi et al., 2017; Markey & Okantey, 2019). National Academies of Sciences, Engineering, and Medicine (NASEM, 2021) recognise that nurse educators are crucial to endeavours that will improve the quality of health care for marginalised groups. However, Gallo et al. (2022) report that nursing faculties lack a comprehensive approach to integrating diversity, equality, and inclusion (DEI) in their curricula and often fail to include syllabi that represent an expansive view of diverse groups. According to the National League for Nursing (NLN, 2016), diversity encompasses differences related to race, ethnicity, gender, age, culture, sexual orientation, physical ability, socio-economic status, political and religious beliefs. They encourage nurse educators to empower their students to embrace diversity and inclusivity, enabling them to meet the challenges posed by the evolving diverse needs of patients in complex healthcare systems. Wright et al. (2021) and Cox et al. (2023) recommend that nurse education must expand its perspective on diversity to include social determinants of health, issues of inequity, privilege, oppression, prejudice, and social justice. Additionally, Smith et al. (2023) believe that nursing faculties must prepare students to address healthcare disparities and racial inequalities through increased awareness of cultural traditions, personal bias, beliefs, and language. Markey et al. (2021, p. 259) posit that nurturing inclusivity in nurse education requires planning that incorporates 'culturally responsive pedagogies to ensure enhanced intercultural integration and equal learning opportunities for students'. However, they also acknowledge that current guidance on promoting and integrating culturally inclusive education in nursing is limited.

A search of educational publications from the regulatory body for Nursing and Midwifery in Ireland (NMBI, 2016) reveals a lack of guidance to support nurses in caring for diverse populations. However, it must be acknowledged that at the time of writing initiatives to improve cultural diversity guidance for nursing faculties are underway. Nurse educators have a pivotal role in preparing future nurses to develop the necessary knowledge and skills to deliver culturally sensitive care (Paric et al., 2021; Morton-Miller, 2013; Montenery et al., 2013). However, some studies suggest that many nurse educators may not possess adequate knowledge, skills, behaviours, and attitudes required to teach students how to deliver culturally competent care (Baghdadi & Ismaile, 2018; Reneau, 2013). These concerns have prompted the nursing profession, to examine concepts that promote the development of a cultural consciousness to understand the needs of diverse populations on a global scale (Azzopardi & McNeill, 2016). Therefore, it is incumbent upon nurse educators to explore transformative pedagogies to enhance their teaching of cultural diversity and to develop their cultural knowledge and skills.

In this study, the concept of cultural humility is presented as a transformative concept that can address the needs of nursing faculties in meeting the global needs of diverse societies. According to Habashy and Cruz (2021), educational reform needs to consider transformational paradigms to negate limited knowledge, unequal partnerships, and perceptions that are currently applied to cultural encounters. In a global context, educational pedagogies and approaches need to emphasise a broader knowledge of cultural contexts as well as foster personal inner growth, ensuring that students become global citizens who are thoughtful, respectful, and empathetic to each other (Habashy & Cruz, 2021). Porter and Schumann (2018) propose that humility should be central to these endeavours to ensure that students are navigating the world through an ontological lens of intellectual humility. However, Habashy and Cruz (2021) recognise the considerable efforts this paradigmatic shift entails for educators, as it requires a move from established practices aligned with competence to involve more humanistic approaches to education. Nonetheless, nurse education should consider incorporating this type of transformational educational endeavours to meet the growing and global contexts of healthcare environments.

1.4 Significance of the Study

This dissertation investigated how nurse educators currently incorporate cultural diversity into educational practice and assessed their perspectives on the need for reform. As a nurse educator, I recognize the importance of providing culturally sensitive care to diverse populations, but I also see that there is room for improving student nurses' preparation to deliver this care. I argue that the consideration of cultural humility in contemporary educational pedagogies has the potential to enhance current educational practices and significantly influence student nurses' ability to deliver

culturally responsive and sensitive care. In today's healthcare landscape, characterised by a dynamic demographic shift and growing cultural diversity, nurse educators need to acknowledge the importance of acquiring the necessary skills to effectively address these evolving needs. Recognising this shift is vital for preparing students to meet the needs of diverse patient populations and for promoting equitable healthcare outcomes. Nurse educators can foster inclusive and culturally sensitive healthcare environments that align with the evolving needs of patients and communities by addressing these gaps in cultural understanding and emphasising the cultivation of the principles of cultural diversity among students. Additionally, by examining cultural diversity and promoting pedagogies that embrace cultural humility, we can cultivate a new generation of nurses capable of providing safe, responsive, and culturally aligned person-centred care.

My motivation for this research stems from a personal experience in an emergency department where I witnessed healthcare workers' lack of knowledge in providing culturally sensitive end-of-life care to a Jewish patient. This incident highlighted the importance of considering specific cultural needs during critical moments, as the patient's customs were overlooked, resulting in unsatisfactory care for the patient, family, and spiritual advisor. This experience sparked my interest in exploring innovative pedagogies that can better equip nurse educators to prepare students to meet diverse patient needs. My participation in the Doctorate in Education (EdD) programme, served as the catalyst for investigating nurses' perceptions and approaches to social justice issues. From this, I focused on cultural diversity, a critical aspect that is intertwined with the broader pursuit of social justice in nursing. By providing insights into the effective integration of cultural diversity, this dissertation aims to contribute to the body of knowledge in nurse education. Nurse educators can enhance their practice by exploring transformative pedagogies that embrace cultural humility. This research aims to offer valuable guidance for fostering inclusive and culturally sensitive learning environments for student nurses.

1.5 Research Aim and Questions

My engagement with the four taught modules in the EdD program greatly influenced the development of this study, shaping my decisions on the research aim and questions. In particular, the Educational Futures (EF) module guided my focus on how nurse education should prepare for the future by encouraging students to adopt a global perspective while practicing in their local contexts (Frenk et al., 2010; Holmgren, 2017). I recognised the significance of incorporating the interconnected aspects of globalization, human health, and healthcare systems into future visions for nurse education. The EF module emphasised the significance of nurse educators and students being self-reflective to foster a sense of social responsibility, particularly in matters related to social justice (Holmgren, 2017). The assigned readings further highlighted the necessity of

incorporating critical perspectives into the social justice discourse within the field of nurse education. This entails addressing social determinants of health and challenging the normative stance of the discipline (Reimer & Browne, 2006) by embracing more socially and culturally oriented interpretations. The recognition of the need to include more social justice issues in educational practise piqued my interest in issues of cultural diversity in nurse education.

My research on this subject led me to explore new and transformative concepts being promoted in healthcare literature to address the issues of cultural diversity. Consequently, further reading on this subject enabled me to examine the concept of cultural humility as a potential response to this dilemma. This prompted me to question whether the adoption of cultural humility in nurse educators' practice could foster critical reflection and examination of the principles of diversity and inclusion within nurse education, shaping students' learning.

The research question acts as a guide in directing the researcher's determination of variables, formulation of hypotheses, research objectives, and the design of a research methodology that aligns with the study's overarching goals (Korstjens & Moser, 2017). This allows investigators to investigate an area of interest, enabling the development of knowledge that offers an original contribution to the field of nurse education.

This research aims are to explore nurse educators' understanding of cultural humility and their perspectives on its potential to enhance student nurses' delivery of culturally responsive and sensitive care. The research questions are as follows;

1. What are nurse educators' current understandings of cultural humility?

> **1. (a)** What approaches do nurse educators currently adopt (if any) to teach about culturally responsive care?
>
> **1. (b)** To what extent do their approaches and/or the principles underpinning them, overlap with the principles of cultural humility?

2. In what ways, if at all, do nurse educators perceive cultural humility to have the potential to enhance their practice of teaching cultural diversity?

This dissertation explores the perspectives of nurse educators teaching cultural diversity in an undergraduate nursing program in the Republic of Ireland. By gaining insights into their current practices, my study aims to contribute valuable knowledge that can enhance the training of future nurses to respond to the increasing cultural diversity within global healthcare systems. The study

will investigate the potential of cultural humility in promoting approaches that can improve the provision of culturally responsive and sensitive nursing care. It aims to assess nurse educators' familiarity with the core principles of cultural humility and the extent to which they incorporate issues of diversity into their current teaching practices. This knowledge can inform the need for new educational pedagogies, educational philosophies, curriculum development, and additional strategies that will enhance culturally responsive and sensitive care in challenging healthcare systems.

1.6 Outline of the Dissertation

Chapter 2 provides an overview of key concepts used to define culture and cultural diversity, including dominant conceptual models in healthcare and nursing. These concepts have evolved and are influential in shaping the current practice of cultural diversity, as well as any initiatives than can be considered for the adoption of cultural humility. It explores the concept of cultural humility as presented in international and national literature, focusing on its potential relevance to nurse education and practice.

Chapter 3 reviews the existing evidence in national and international literature, exploring themes related to the practice of culturally responsive and sensitive care in nurse education. It also considers literature promoting cultural humility as a transformative pedagogy for teaching culturally responsive care to diverse patients, encompassing other disciplines.

Chapter 4 outlines the methodology used in the study, discussing the chosen research paradigm, data collection methods, reflective thematic analysis, ethical, and trustworthy considerations.

Chapter 5 presents the research findings in-depth, including themes, sub-categories, participant interview narratives, and interpretations from the primary researcher.

Chapter 6 analyses and interprets the findings, offering insights and implications drawn from the study.

Chapter 7 evaluates the study's strengths and limitations, accompanied by recommendations for both nursing education practice and future research. It also gives personal insights into my journey as a researcher throughout the course of this study

Chapter 2 Key Concepts and Perspectives of Cultural Diversity

2.1 Introduction

Initiating a paradigmatic and philosophical shift in the practice of cultural diversity within nurse education is essential. This requires revisiting key concepts and perspectives related to the definition of culture and cultural diversity in healthcare. Being aware of cultural contexts helps nurse educators identify cultural assumptions and their impact on patient care, an aspect that is often mistakenly assumed to be universal. The concepts of cultural competence and cultural humility will be explored in this chapter as these are key to addressing the research aim and questions of this study. This exploration can empower nurse educators to continually evaluate and improve their practice, to ensure that student nurses are prepared to provide culturally responsive and sensitive care to diverse populations.

2.2 Key Perspectives of Culture in Healthcare

As a result of its complex nature, there are many definitions of culture that inform healthcare practice (Locke, 1992; Hofstede, 2001; Campinha-Bacote, 2002; Leininger & McFarland, 2006; Purnell, 2013). Culture is often recognised as a social determinant of health, as it considers the influence of individual experiences, values, and beliefs, in shaping healthcare behaviours (WHO, 2015). When intersecting with socioeconomic disadvantage, cultural values can contribute to the stigmatisation and marginalisation of diverse patients and determine access to culturally sensitive care (Public Health Agency of Canada, 2014). In this context, an individual's cultural background - inclusive of religion, ethnicity, minority status, and customs - is important in establishing how they perceive their healthcare services, their personal experiences of healthcare, and their interactions with practitioners (Maesschalck et al., 2011). Locke (1992, p. 3) regarded culture as 'socially acquired and socially transmitted by means of symbols, including customs, techniques, beliefs, institutions and material objects'. This definition implies that culture is not predetermined but can be learned through specific characteristics of culture from birth. Hofstede (2001, p. 9) characterised culture as a 'collective programming of the mind that distinguishes the members of one group or category of people from another'. However, these definitions have limitations in their scope, as they fail to acknowledge characteristics such as colour, race, or ethnicity. Additionally, they often fail to consider the influence of personal experience and worldviews, which can determine individual perceptions of illness and health. Dayer-Berenson (2014) suggests that individuals from distinct racial groups often diverge in their experiences, leading to different perceptions of the environment in which they are situated. This is particularly relevant in the healthcare arena, where patients may interpret illness differently compared to their counterparts and the healthcare providers they interact with (Good & Good, 1981).

One of the key transcultural nursing theorists, Leininger (2001, p. 46) defined culture as 'learned, shared, and transmitted values, beliefs, norms, and lifeways of specific individual or group that guide their thinking, decisions, actions, and patterned ways of living'. This definition significantly influenced the development and evolution of frameworks in nursing, especially those related to cultural competence. Such frameworks attempted to align nursing care with understandings of culture. They not only referred to socially constructed ideas around ethnicity, race, religion, gender, or colour but also acknowledged the influence of economic status, educational background, and personal experiences, values, and beliefs on the patient's healthcare journey. As such the evolving nature of the patients' experience with illness, whether acute or chronic was largely responsible for the development of explanatory models of healthcare (Laws, 2016).

Kleinman (1980) conceptualised the first model of explanatory health and illness as a guide to healthcare practitioners to understand how patients interpret their illness from a cultural perspective. The explanatory model (EM) views the patient's approach to health and healthcare as complex and culturally determined, facilitating personal understandings of illness that ascribe meanings to symptoms, treatment decisions, and healthcare behaviours. Kleinman's model allows practitioners to investigate cultural underpinnings of illness where traditional biomedical models are seen to be limited (Mkabile & Swartz, 2020). Kleinman further elaborated on the individual and collective beliefs that shape individual experiences and behaviours when patients are ill. He argued that cultural background was crucial in influencing how individuals present with an illness, define health and determine their decisions about treatment plans and compliance. Therefore, the model elucidates how patients construct their explanatory models based on their evolving experiences of illness. These models do not consider culture as fixed or static but can evolve and change according to different phases of an individual's healthcare journey. As patients experience different phases of their illness they often gain new insights, which can transform their beliefs and perceptions about their health (Kleinman, 1980). Tirodkar et al. (2011) posit that each individual's explanatory model is essential for understanding the influences of their social, past experiences, and cultural backgrounds. Kleinman's explanatory model (1980) had a significant influence on earlier interpretations of culture in healthcare settings and understanding its underlying principles was instrumental in promoting positive health behaviours and improving adherence to treatment plans (Laws, 2016). However, Habte et al. (2016) caution practitioners to recognise the differences between patients' and medical practitioners' views of health, as these disparities can lead to poor adherence to treatment plans and affect healthcare outcomes.

Laws (2016) argues that current interpretations of the explanatory model can over-rely on the biomedical aspects of health and mechanistic understandings of diseases, such as Human

Immunodeficiency Virus (HIV). In this study, a cohort of patients with HIV indicated that factors beyond biomedical aspects played a significant role in shaping their explanatory models. The patients did not think that current healthcare practices reflected holistic factors such as a trusting relationship with healthcare providers, or personal beliefs and emotions, that were inherent in their explanatory model. Tirodkar et al. (2011) explored the explanatory model of health and illness of Southeast Asians and found comparatively diverse interpretations of disease and health. The participants emphasised the importance of recognising the relationships between bio-psycho-social factors in healthcare practices. The authors noted differing perspectives in their study, with Muslim participants placing specific emphasis on spiritual factors in their explanatory models. This indicates that healthcare needs to become more aligned with individual explanatory models in the pursuit of providing culturally responsive and sensitive care to patients. Similarly, Ziegler et al. (2022) recognise the complexities of caring for diverse patients, advocating for the incorporation of holistic approaches that focus on individual patient perspectives, identities, and healthcare needs. They recommended that healthcare practitioners explore their inclination to depend on essentialist perspectives of culture in their pursuit of person-centred approaches to diversity in their practice.

Gray and Thomas (2006) advocate for healthcare providers to reconsider their approaches to providing cultural care through the narrow lens of cultural competence. This narrow lens can limit their practice of diversity, restricting knowledge development to traditions and characteristics of specific cultural groups (Vandenberg & Kalischuk, 2014). According to Gray and Thomas (2006), the essentialist view of culture uses the lens of ethnicity, race, and religion aligned with specific cultural groups to understand the distinct individual characteristics of people. This perspective defines culture as stable and unyielding, where individuals share a homogeneous set of beliefs, behaviours, and values (Gray & Thomas, 2006). However, this essentialist lens fails to recognise the dynamic and fluid nature of culture which is shaped by social, historical, and political contexts (Vandenberg, 2010). Consequently, essentialism designates individuals into predefined social groups, reinforcing assumptions, generalizations, and stereotypes about their healthcare needs, behaviours, and preferences. As a result, practitioners can often hold simplified and reductionist views of culture, failing to recognise the diversity of individual experiences, culture, and identities (Gray & Thomas, 2006). Bourque-Bearskin (2011) argues that this perspective can focus nurses' attention on categorisations, thereby hindering their ability to recognise the uniqueness and fluidity of individual cultural identities. Essentialist views of culture, while helpful in focusing on understanding different worldviews, have also failed to account for different value systems in specific cultures (Vandenberg & Kalischuk, 2014). Williamson and Harrison (2010) also purport that educational programs supporting essentialism, which merely emphasise the beliefs, values, or

traditions specific to certain cultural groups, promote a narrow view of culture. This perspective may perpetuate stereotypes in healthcare and promote relativism, encouraging acceptance of cultural practices that ignore the broader political, historical, and economic power dynamics inherent in social groups (Vandenberg & Kalischuk, 2014, p. 100).

Extreme essentialist views of culture became synonymous in health care when they were compared with to the dominant norm of white, English-speaking middle-class populations (Vandenburg, 2010). Nursing scholars have criticised this perspective, arguing that it embodies divisive opinions that perpetuate prejudice and stereotyping in the field (Johnson et al., 2004). Langstedt (2018, p. 293) argues that the essentialist view of culture aims at 'othering' people by categorising them as non-western, undermining the agency of the individual in terms of their diverse cultural backgrounds. The essentialist perspective regards culture as a disposition that is inherent in the individual (Dahl, 2014). From this viewpoint, individuals are seen as embodying the cultural norms, values, and traditions of their social group from birth, shaping their worldview, behaviors, and interactions with others. Such static views assume that culture is a tradition often continued through generations which continues to neglect the societal transformations that occur due to technical, environmental, and social factors (Illman & Nynäs, 2017; Nathan, 2015). The idea that culture is homogenous neglects factors related to diversity, failing to represent global changes evident in today's multicultural world (Illman & Nynäs, 2017; Nathan, 2015). As such, Langstedt (2018) questions this view of culture as a determination of human behaviour, which portrays the individual as a passive agent challenged to adapt to different cultural contexts. According to Vandenburg (2010), this essentialist view is prevalent in nursing practice, encouraging practitioners to perceive categorisations as objective facts while neglecting the social constructs that influence them (Gray & Thomas, 2006). While Vandenburg (2010) argues against this uncritical acceptance of categorising groups in terms of culture in nursing, others express concern about the prevalence of this minimalist lens in frameworks guiding the care of culturally diverse patients (Hollinsworth, 2013; Jani et al., 2011).

Grillo (2003; 160) believes that in growing diverse societies, the view of culture needs to place more 'emphasis on multiple identities or identifications whose form and content are continuously being negotiated'. These perspectives have significant implications in nurse education, as comparisons between non-nursing students and nursing candidates revealed that the nursing cohort demonstrated dominant essentialist views of culture (Gregory et al., 2010). This has led advocates to propose a view of culture developed on socially mediated processes, in contrast to defining it as a set of characteristics or traits (Gustafson, 2005; Gray & Thomas, 2006; Lynam et al., 2007).

Therefore, these authors propose further research to establish whether existing nursing pedagogies perpetuate essentialist views of culture in their philosophies and approaches.

Vandenberg and Kalischuk (2014) also found that essentialist views of culture persist in nurse education, where students tend to narrow their cultural care to focus exclusively on ethnicity and race. This study found that nursing students' understanding of culture was limited to cultural differences, increased intercultural communication, and the importance of the cultural encounter in the therapeutic relationship. The study also observed that nurse educators did not encourage their students to critique their views of culture or to explore more constructivist perspectives. The researchers recommended that both nurse educators and students should critique different perspectives of cultural care models, assess the pros and cons of acquiring cultural knowledge in isolation, and broaden their approaches to cultural care. One such view espoused by anthropologists advocates for constructivist views of culture as 'a product of social constructions' (Blanchet-Garneau & Pepin, 2015, p. 10).

From the constructivist view, culture considers the individual as a holistic whole, rather than simply a product of a set of behaviours and beliefs (Blanchet-Garneau & Pepin, 2015, p. 10). Hudelson (2004, p. 345), explains that 'most anthropologists would define culture as the shared set of (implicit and explicit) values, ideas, concepts, and rules of behaviour that allow a social group to function and perpetuate itself'. Therefore, constructivist views of culture also consider the co-existing, overlapping, and competing subcultures involved in dynamic and complex societies (Hudelson, 2004, p. 345), including healthcare environments. Blanchet-Garneau & Pepin (2015) promote the constructivist view in healthcare as it facilitates the fluid and dynamic process of culture that bears shared and diverse meanings in individual interactions. Within this view, culture encompasses the constantly evolving historical, social, and economic context that influences cultural diversity (Gregory et al., 2010). This perspective requires the practitioner to be more critically reflective and active in adapting their knowledge and skills when interacting in different cultural contexts (Blanchet-Garneau & Pepin, 2015). The recognition of culture as evolving and fluid implies that individual interpretations of the world and their behaviours can change at any given time. Nonetheless, healthcare still adopts oversimplified approaches to culture based on the development of specialised knowledge of particular cultural groups (Blanchet-Garneau & Pepin, 2015). Gray and Thomas (2006) suggest that culture involves an ongoing process of transmitting and using knowledge, dependent on societal dynamics and global networks, and is not limited to race and ethnicity. Nonetheless, Taylor (2003, p. 555) argues that 'the institutional culture of medicine and medical education sees itself as a 'culture of no culture' and systematically tends to foster static and essentialist conceptions of culture to patients. Nadan

(2014, p. 5) suggests that cultural competence tends to focus on gathering factual information about different cultures, resulting in rigid and uniform perspectives of the other. He advocates for adopting more constructive and reflexive views of culture in healthcare interpretations of cultural competence.

This study aligns with constructivist ideas of culture, as it seeks to promote transformative pedagogies such as cultural humility in healthcare education. Constructivism, views culture as a dynamic and fluid product of social constructions, acknowledging the coexistence of diverse subcultures. The study explores the potential of cultural humility in developing an understanding of individuals as holistic beings, recognizing the ever-evolving historical, social, and economic contexts that shape their healthcare journeys. Cultural humility encourages healthcare practitioners to adopt a reflexive and adaptive approach to cultural differences promoting a move beyond static and essentialist conceptions of culture. This constructivist perspective advocates for continual learning, critical reflection, and active adaptation to individual cultural contexts, fostering a more nuanced and respectful engagement with diverse patient experiences.

2.3 Cultural Competence

To examine the concept of cultural diversity in nurse education, it is important to explore the influence of the dominant model of cultural competence (Danso, 2018) used in healthcare education. According to Danso (2018), cultural competence was seen as revolutionary and has made a significant contribution to cultural care in healthcare. Cultural competence has been described as ‘skills that a clinician can employ to understand the cultural values, attitudes, and behaviours of patients, especially those whose cultural background differs from that of the professional’ (Schouler-Ocak et al., 2021, p. 432). According to Jernigan et al. (2016, p. 1), culturally competent individuals are considered to have ‘the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities’. Cultural competence was originally adapted from the transcultural nursing theory (Leininger, 2002) which promotes culturally congruent care through critical inquiry into cultural differences, similarities, and their influence on diverse patients (Mahara et al., 2011). Leininger's ideas have influenced the development of many models of cultural competence for nursing practice, including Giger and Davidhizar's (1990) Transcultural Assessment Model, The Purnell Model of Cultural Competence (Purnell, 2002), and Campinha-Bacote's (2002) Culturally Competent model of care. In particular, Campinha-Bacote's (2002) model is used to guide proficiency in cultural competence in five key areas that operate both independently and cohesively together in nursing. These areas include cultural knowledge, cultural encounters, cultural awareness, cultural skills, and cultural desire. The model requires practitioners

to consider two elements of the concept; culture and competence. Whilst the model recognises the socially constructed elements of culture it also requires the practitioner to become competent, which entails a lifelong commitment to learning and adapting. As cultural competence became more integrated into professional standards globally, studies emphasised that it was beneficial in increasing cultural knowledge, skills, and attributes, and promoting patient satisfaction (Cabral & Smith, 2011; Ceballos & Bratton, 2010). Cai (2016) argues that cultural competence in nurse education especially is crucial in a climate of declining standards of care. Therefore, the development of cultural competence remains critical for training student nurses (Repo et al., 2017; Wang et al., 2018) to ensure good patient outcomes in healthcare systems.

Nonetheless, concerns persist about the efficacy of cultural competence to guide practitioners in delivering culturally sensitive care to diverse patients (Harkess & Kaddoura, 2016; Červený et al., 2022). Reports of insufficient cultural competence skills have been reported in student nurses (Wang et al., 2018; Cruz et al., 2018; Halabi & de Beer, 2017), healthcare practitioners (Papadopoulos et al., 2016), and nurse educators (Paric et al., 2021; Marzilli, 2016; Montenery, 2013). Others have found that strategies to embed cultural competence in nurse education lack the required support to ensure successful outcomes (Paric et al., 2021; Liu et al., 2018; Jernigan et al., 2016) leaving nurse educators to bear the responsibility for its integration in their practice (Paric et al., 2021). These reports highlight the continuing difficulties with cultural competence as a strategy to prepare healthcare practitioners to meet the needs of the diverse communities they serve. As a result, alternative approaches to cultural diversity in healthcare, using more transformative concepts, such as cultural humility continue to be promoted in the literature (Danso, 2018; Foronda et al., 2016; Danso, 2015; Fisher-Borne et al., 2015).

2.4 Cultural Humility in Health Care

Cultural humility, a concept pioneered by Tervalon & Murray-García (1998), holds significant promise for improving the practice of cultural care in global healthcare settings. Tervalon & Murray-García (1998) viewed cultural humility as a lifelong approach to train physicians to deliver culturally appropriate medical care, through the processes of self-reflection. Their original definition of cultural humility is a ‘commitment and lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues and themselves’ (Tervalon & Murray-García, 1998, p. 118). In contrast to cultural competence, cultural humility recognises the dynamic nature of culture by emphasising the practitioner’s responsibility in examining their biases, values, beliefs, and cultural identity. This serves to lay the foundation for building honest and trustworthy relationships in healthcare. Cultural humility depicts a continuous personal journey of introspection aimed at recognising cultural differences to promote inclusivity in care plan

decisions. As a concept, cultural humility embraces the intrinsic value of cultural differences present in the therapeutic relationship between practitioner and client (Tervalon & Murray-García, 1998). These relationships based on the premise of humility recognises the need for the practitioner to relinquish the role of power, control, and authority, adopting the role of student to the client (Tervalon & Murray-García, 1998). Hence, cultural humility differs from cultural competence in that it engages the practitioner in a lifelong learning process with less emphasis on mastering cultural knowledge (Fisher-Borne et al., 2015) and instead promotes greater engagement with lifelong processes of self-reflection and critique that redresses power imbalances (Tervalon & Murray-García, 1998; Danso, 2018; Smith & Foronda, 2021; Foronda et al., 2016; Fisher-Borne et al., 2015; Yeager & Bauer-Wu, 2013).

According to Tervalon & Murray-García (1998), discrepancies in care arise when the healthcare provider does not take time to understand the uniqueness of culture, and its implications for individual health and healthcare needs. This may lead healthcare providers to unknowingly adopt positions of ethnocentricity, which can contribute to a power imbalance between the client and the healthcare provider. A concept analysis of cultural humility by Foronda et al. (2016, p. 211), emphasises necessary attributes required for the practitioner to practice cultural humility; self-awareness, openness, supportive interaction, self-reflection, egolessness, and critique. They also identify preceding antecedents as the presence of power imbalances and exposure to diverse multicultural environments and situations. Interestingly, following their concept analysis, Foronda et al (2016) emphasised that cultural humility should be more about personal transformation rather than the acquisition of knowledge of different cultures. The adoption of cultural humility by the caring professions is seen as instrumental in fostering openness to multiple perspectives and enabling practitioners to examine their own knowledge and skill limitations (Danso, 2018; Hook et al., 2013). Therefore, unlike cultural competence, cultural humility does not solely emphasise mastery of cultural knowledge; instead, it engages practitioners in an ongoing and lifelong process of self-reflection, personal transformation, and critique (Fisher-Borne et al., 2015; Tervalon & Murray-García, 1998; Danso, 2018; Smith & Foronda, 2021; Foronda et al., 2016; Yeager & Bauer-Wu, 2013). Another pivotal dimension of cultural humility lies in its emphasis on the importance of healthcare providers recognizing how their personal biases and assumptions regarding diverse individuals can influence the provider-client relationship and their approach to healthcare (Yeager & Bauer-Wu, 2013; Danso, 2018). The examination of personal bias is crucial in the pursuit of reducing discriminatory behaviours and developing intrapersonal skills (Hughes et al., 2020; Markey et al., 2021). The interpersonal aspects of cultural humility can only be realised when practitioners understand and question cultural beliefs and values inherent in the culture of those they serve, their families, and their colleagues (Hughes et al., 2020).

The Rainbow theory of cultural humility devised by Foronda (2020) provides valuable guidance for healthcare professionals who are developing their understanding of cultural humility in practice. It provides a framework for practice that uses the analogy of a rainbow to describe intersecting elements of cultural encounters such as personal beliefs, historical contexts, physical environment, political climate, and situational context (Foronda, 2020, p. 9). All these elements intermingle to give an overall context of individual, community and group perspectives and the differences within them. The theory provides clarity for practitioners to examine how these contextual factors, power imbalances, and perspectives, influence healthcare decisions and patient outcomes. This enables them to understand and address the potential for conflict and ambivalence in cultural encounters enhancing awareness of diversity to develop lifelong practices that will ensure culturally sensitive care is delivered to diverse populations. Foronda (2020, p. 9) recognises three 'distinctions and actions' that can benefit the challenges inherent in cultural encounters, (1) to make use of cultural humility, (2) to be culturally ambivalent, or (3) to be culturally destructive. Of these three approaches Foronda (2020) suggests that cultural humility is the only approach that will lead to positive outcomes in the therapeutic relationship. The emphasis on flexibility, openness, and respect inherent in cultural humility promotes positive relationships, contrasting significantly with the characteristics of cultural ambivalence or destructiveness. While the rainbow theory integrates ideas from experts in cultural humility it emphasises flexibility as the key to the process of developing a lifelong commitment to self-reflection, self-awareness, respectfulness, egolessness, openness, and recognition of power imbalances.

Luctkar-Flude et al. (2021) used the rainbow theory as a framework to ground their study to develop new teaching initiatives that would promote understanding of nursing care related to the LGBTQI2S (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Two-Spirit) community. They used an educational initiative that integrated immersive virtual simulation games with online preparation materials to strengthen students' cultural humility skills. The theory allowed them to explore the experiences of the LGBTQI2S community through social, historical, and cultural contexts that frame individual experiences. This integrative approach allowed them to bridge gaps in their knowledge, and promote cultural humility and inclusivity while developing empathy and respect for this diverse group. Frie and Timm (2023) used a cultural humility scale to develop an interprofessional internship program during the COVID-19 pandemic. The cultural humility scale was designed using key constructs from previous work, particularly the rainbow theory (Foronda 2020; Foronda et al., 2016). The study reported increased cultural humility scores, awareness of healthcare disparities, and enhanced engagement with self-reflection related to the diverse beliefs, values, and practices of patients. In this study, I propose that the theory of cultural humility serves as a guiding framework for examining nurse educators' understanding of cultural humility and

their perspectives on its potential to enhance student nurses' delivery of culturally responsive and sensitive care. By examining the potential of cultural humility in shaping educational approaches and fostering a climate of inclusivity and respect within nursing programs, this research seeks to contribute valuable insights to the existing literature on culturally sensitive healthcare delivery. Furthermore, by elucidating the mechanisms through which cultural humility can potentially inform pedagogical strategies and curriculum development, this study aims to offer actionable recommendations for educators and policymakers seeking to enhance the cultural competence of future nursing professionals.

Interestingly, Habashy and Cruz (2021, p. 20) view cultural humility as a disposition, which is crucial in developing problem-solving practitioners to work effectively in global contexts. Integral to the concept of cultural humility are dispositions of respect, critical self-reflection, and empathy both from an interpersonal and intrapersonal perspective (Hook et al., 2013; Hughes et al., 2020). On an interpersonal level, practitioners are expected to adopt respectful and open acceptance of the patient's cultural perspectives of the world. While the interpersonal element entails a personal responsibility to remain aware of their limitations (Hughes et al., 2020). Therefore, central to the practice of cultural humility is the requirement to take both personal and professional accountability for their practice (Fisher-Borne et al., 2015) and for their cultural interactions with other individuals (Isaacson, 2014). In their study, Habashy and Cruz (2021) challenge the notion that dispositions cannot be taught to students in traditional classroom settings. Their study focused on student engagement aimed at developing essential dispositions using classroom-based assignments, related to the practice of cultural humility. They found that when taught as a disposition, cultural humility enables students to adopt lifelong approaches to practicing self-reflection to develop deeper understandings of different perspectives. This also encourages them to develop dispositions that will enable them to approach cultural encounters with respect, openness, curiosity, and acceptance. This has significant implications for global learning and educational practices that are fostering future healthcare workers to be more understanding of cultural differences and identities. Therefore, cultural humility has the potential to contribute to a better understanding of cultural diversity and its impact on patient care (Marshall et al., 2017).

Like other healthcare professionals, nurses must acquire the skills, knowledge, and understanding to incorporate inclusivity in their care planning and establish therapeutic relationships with patients from diverse backgrounds, (Marshall et al., 2017). Nurse educators are pivotal in developing students' knowledge and skills required for building these relationships with diverse patients to meet their individual healthcare needs (Marshall et al., 2017). A lack of cultural understanding can impede the development of meaningful relationships between client and practitioner, affecting

their ability to care for patients from different backgrounds (Marshall et al., 2017). According to Lekas et al. (2020), cultural humility offers a framework to develop insight into patients' lived experiences while encouraging immersion within various cultural contexts. According to Hughes et al. (2020), cultural humility offers an approach for practitioners to deepen their understanding of multiple perspectives and cultural fluidity. In this respect, cultural fluidity encourages them to navigate between the differences in values, perspectives, and beliefs held by people in daily cultural encounters (Hughes et al., 2020, p. 31).

There is no doubt that cultural humility has the characteristics to transform cultural care to meet the demands of complex and diverse healthcare communities. According to Frie and Timm (2023, p. E153), tertiary education in healthcare needs to explore cultural learning methods that do not merely emphasise differences in cultural identities. They purport that these methods may not adequately prepare healthcare practitioners and are liable to contribute to stereotyping, bias, and misinformation. However, the aim of this dissertation is not to dismiss the significant contribution of cultural competence models to healthcare settings, but rather to explore the potential of cultural humility in enhancing the delivery of culturally sensitive care. Indeed, new configurations of cultural competence have expanded their perspectives to align with Tervalon & Murray-García (1998) ideas of committing to continuous individual development and learning about the self to improve understanding of cultural diversity. Nonetheless, it is notable that cultural humility is consistently offered as a divergent perspective to address continuing gaps in the delivery of culturally responsive and sensitive care in healthcare. Danso (2018) presents an engaging critical discussion about the similarities of both concepts emphasising that conceptual fragmentation and misinterpretation of cultural competence have led to arguments for replacement in the literature. Danso cautions scholars in social work to understand that cultural humility also lacks clarity and can be challenging in terms of navigating the practitioner and client's individual beliefs and value systems. Danso (2018) also raises concerns about its practicality in a clinical or organisational setting, questioning its credibility as a cross-cultural framework. Campinha-Bacote (2018) a prominent nursing theorist suggests that paradigm shifts that look to replace cultural competence with humility require further exploration. She designed a conceptual framework that promotes a synergistic relationship between the two concepts. Her framework integrates the characteristics of cultural humility across the five components of cultural competence including knowledge, skill, awareness, interactions, and desire. However, this process requires healthcare practitioners to re-evaluate the concept of humility, which is often perceived as easier than when individuals pay less attention to it. Drawing parallels with theology, she suggests ways in which humility can be practiced, such as serving others, admitting personal mistakes, cultivating gratitude, positive attitudes toward others, and responding well to constructive feedback.

In embodying both frameworks, Campinha-Bacote (2018) suggests that healthcare practitioners can promote humility, understanding, sensitivity, and empathy in their interactions with diverse patients and communities. Tervalon & Murray-García (1998, p. 119) believe that the mere acquisition of knowledge about culture, without personal adjustment of one's attitude and behaviours was of 'questionable value.' They believe that practitioners who approach patients with humility are more client-focused, embracing a collaborative relationship in which they relinquish the role of an expert as the sole authority in control of proceedings, adopting a more capable partnership approach. Hook (2014, p. 3) suggests that the practice of humility encourages practitioners to adopt a less 'rigid picture of what the client should look like to be healthy or functional' and instead is more inclined to acknowledge their 'worldview and goals' in the context of their healthcare journey.

2.4 Summary

This chapter has explored the need to examine current interpretations of culture and other concepts that guide the practice of cultural diversity in nurse education and healthcare. These interpretations have largely shaped the methods employed to address cultural diversity in healthcare, often manifesting as competence models. Unfortunately, these perspectives often offer static and inflexible views of culture leading to poorer healthcare outcomes and satisfaction rates for diverse patients. In particular, cultural competence has been the dominant paradigm used to guide the delivery of cultural care to diverse communities. There is still a consensus on the international healthcare stage that professionals need to be culturally competent. Indeed, the proliferation of literature that is generated on cultural competence in healthcare is a testament to its continued popularity. However, despite its widespread use in healthcare, there are distinct challenges with its application to guide the delivery of culturally responsive and sensitive care. Educational training and toolkits operationalised through cultural competence have been criticised for promoting generalisations in cultural care delivery. The challenge for educators often lies with the conceptualisation of culture which can reflect the needs of specific population groups, as opposed to addressing the individual needs of the individual.

In response to these challenges, numerous concepts, frameworks, and models have been proposed as alternatives to cultural competence. One notable approach places emphasis on humility and respect as central attributes in striving to deliver culturally responsive and sensitive care to diverse communities. Cultural humility has emerged as a catalyst for a transforming pedagogy as it fosters values of respect, openness, and mutual empowerment, to foster deeper understandings of cultural diversity. In contemplating the concept of cultural humility, nurse educators and students can

create more inclusive healthcare environments that will respect individual experiences, beliefs, and values.

Chapter 3 Literature Review

3.1 Introduction

A literature review was conducted to ensure the validity and contextualization (Green et al., 2006) of my empirical study within the cultural aspects of the nursing profession. The literature review is considered beneficial for describing the history and development of a topic (Green et al., 2006) and for enabling broader cross-disciplinary searches (Baethge et al., 2019, p. 2) to assess the state of the art of existing knowledge on the subject and identify any gaps or omissions. There is a paucity in the nursing literature on cultural humility, which required me to review the existing evidence-based research on the dominant concept of cultural competence and its contribution to healthcare.

3.2 Literature Search Strategy

I conducted an exhaustive literature search to ensure the inclusion of the most recent and relevant evidence-based studies. The search strategy encompassed a wide array of databases and search engines to cover diverse perspectives. Key databases included Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO, PubMed, Science Direct, Ovid, Applied Social Sciences Index, Cochrane Database of Systematic Reviews (CDSR), SCOPUS, PsycINFO, Web of Science, Dissertation Abstracts, Database of Abstracts of Reviews of Effects (DARES), and Excerpta Medica Database (EMBASE). This extensive range aimed to ensure a comprehensive capture of pertinent studies.

Relevant nursing texts and publications from professional organizations such as the Nursing and Midwifery Board of Ireland and the Health Service Executive (HSE) were also consulted. Internationally, literature from organizations like the American Association of Colleges of Nursing (AACN) and the National League for Nursing (NLN) was reviewed. These organizations are known for their commitment to addressing racism in nursing education and promoting diversity, equity, inclusion, belonging, and justice.

Interdisciplinary perspectives were integrated by incorporating research data from related professions such as social work and psychology. This broadened the scope and provided a comprehensive understanding of the topic. The global literature was contextualized to the Irish setting by comparing and contrasting international findings with local data, highlighting unique cultural, social, and economic factors.

To ensure no relevant studies were overlooked, manual searches of journals related to cultural diversity, transcultural nursing, and cultural humility were performed. This process involved systematically reviewing the tables of contents of key journals and handpicking articles that

addressed the research topics. Although time-consuming, manual searches often proved rewarding in uncovering articles that might not have been captured through database searches due to indexing limitations or keyword variations. A general time frame of five to ten years was applied to the age of the works included, with seminal or influential works as exceptions to ensure foundational research was not excluded.

A variety of search terms encapsulating the core concepts and objectives of the research were employed. Keywords included terms such as culture, cultural diversity, cultural competence, cultural sensitivity, cultural awareness, cultural humility, transcultural nursing, transformative pedagogies, diverse patient care, inclusivity in education, and teaching strategies for diversity in nursing education. To enhance precision, Boolean operators such as AND and OR were employed. The search was extended to institutional repositories like Rian (Irish institutional repositories) and Lenus (Irish Health Repository), as well as educational and social science databases including the Australian Education Index, British Education Index, ERIC, and Professional Development Collection (EBSCO Host). The strategic use of Boolean operators refined the search process: the OR operator captured all possible variations of a term (e.g., "cultural competence OR cultural awareness OR cultural sensitivity"), while the AND operator focused on specific intersections of topics (e.g., "nursing education AND cultural competence"). Additionally, combinations of terms such as "patient-centered care AND diversity OR inclusivity" were used to ensure comprehensive coverage of the literature. This method guaranteed a broad and in-depth capture of relevant studies, resulting in a rich diversity of perspectives and insights.

However, the use of search terms also presented several limitations. The specificity and variability of terminology across different studies and disciplines could lead to the inadvertent exclusion of relevant studies using alternative phrasing. For example, differences in terminology like "cultural awareness" versus "cultural competence" might result in missed articles. Variations in indexing practices and keywords across databases could also affect the retrieval of relevant studies, introducing potential bias. Language barriers and access restrictions to certain databases posed additional challenges, potentially limiting the inclusivity of the search results. Despite careful selection and combination of search terms, the dynamic nature of academic publishing makes it challenging to capture all current research. To mitigate these limitations, supplementary methods such as manual searches of key journals and iterative search strategies were employed to ensure a broader and more inclusive capture of relevant literature.

The literature review was structured to provide a coherent narrative synthesizing existing research and highlighting key themes and gaps related to cultural diversity and humility. The literature was

organized thematically, with each section addressing a specific aspect of the research topic. Major themes included:

- The landscape of cultural diversity in nurse education
- The role of nurse educators in teaching cultural diversity
- Integrating cultural humility in nurse education
- Examining bias among nurse educators
- Exploring dominant narratives in nurse education
- Culturally responsive nurse education
- Teaching strategies
- Student diversity

This thematic organization facilitated a logical flow of information and allowed for an in-depth exploration of each topic. A comparative analysis of global and local studies was incorporated, contrasting international findings with local data from the Irish context to highlight unique cultural, social, and economic factors influencing the research topic.

Interdisciplinary perspectives from related disciplines such as social work and psychology were integrated to provide a broader context. In reading the literature I ensured that I included a critical evaluation of existing literature, identifying strengths, weaknesses, and gaps. This critical perspective emphasises areas where further research is needed and highlights the contributions of the current study to advancing knowledge in the field. The literature review concludes with a synthesis of key findings and their implications for the research study.

3.3 Landscape of Cultural Diversity in Nurse Education

Wright et al. (2021) advocate for nursing faculties to reinforce the inclusion of DEI in their programs to ensure that the healthcare needs of diverse populations are met. In Ireland, nursing faculties are guided by Nursing and Midwifery Board of Ireland (NMBI, 2016) standards and requirements for student nurse preparation. Professional regulatory bodies have a responsibility to drive structural and systemic changes in nursing policy to ensure healthcare systems cater to their service users' needs (Butler et al., 2018). Despite these global calls to action, the attention to DEI in the NMBI documentation (2016) has been insufficient in guiding Irish nurse educators in practicing cultural diversity. This aligns with findings by Wright et al. (2021), who note inadequate inclusion of DEI in nursing programs due to a lack of organizational effort, leading to adverse effects on healthcare outcomes for diverse patients. Current proposals in Ireland aim to address these deficits in newer NMBI publications, ensuring that DEI content is embedded into nursing curricula nationally. The AACN (2021) emphasizes the role of nurse educators in upholding DEI principles when preparing future nurses for practice in diverse societies. Therefore, there is an

onus on nurse educators to prepare students to promote inclusive nursing care to meet the needs of a changing demographic of diverse patients. Sommers and Bonnel (2020) suggest that incorporating cultural diversity into all facets of nurse education requires proactive management, new pedagogies, and educational resources. However, Wright et al. (2021) believe that there has been inadequate inclusion of DEI in nursing programs due to a lack of organizational effort, which has led to adverse effects on the healthcare outcomes of diverse patients.

The global imperative to improve DEI in nurse education is mirrored in Ireland, where Markey and Okantey (2019) suggest that the application of cultural care models in health care educationis deficient, despite the recognized need to create workforces proficient in navigating the complex care of diverse patients (Almutairi et al., 2017; Markey et al., 2018). In advancing the scrutiny of existing practices in nurse education, perspectives from the Irish context (Markey, 2020; Markey & Okantey, 2019; Markey et al., 2018) resonate with global literature, emphasizing the necessity for faculties to integrate content on social determinants of health, health disparities, health equity, anti-racism, unconscious bias, cultural sensitivity, and awareness (Thornton & Persaud, 2018; AACN, 2017; Cox et al., 2023; Brown & Waller, 2022; Markey et al., 2019). O'Connor et al. (2019) state that nurses need to address the challenges associated with the integration of cultural diversity in practice if they are to prepare students to care for diverse patients. Markey et al. (2021) suggest that nurse managers in Ireland have a significant responsibility to ensure that cultural diversity is a core value in nurse education and in promoting cultural awareness and sensitivity to the development of this area of practice. Other sources believe that faculties need to address the lack of DEI by designing transformed policies, engaging in strategic planning, and promoting changed behaviours and attitudes of faculty members (Cox et al., 2023; Johnson-Mallard et al., 2019; Breslin et al., 2018). A crucial first step in this endeavour is for nurse educators to assess their practice of cultural diversity to inform personal and systemic future transformations to improve inclusivity in education.

3.3 Cultural Diversity: The Nurse Educators' Role

Nurse educators play a pivotal role in embedding DEI in their practice to ensure that the future healthcare workforce of nurses is prepared to care for diverse patient groups. As part of their remit, they need to model culturally appropriate behaviours and adopt strategies that will foster deeper explorations of cultural differences (Gibbs & Culleiton, 2016; Marzilli, 2016; Montenery et al., 2013). This role expects them to employ diverse teaching strategies, create inclusive learning environments, address student needs, collaborate with colleagues, and act as role models for diversity (Chen et al., 2018; Marzilli, 2016). However, studies consistently report that nurse educators lack adequate levels of cultural competence (Majnoon et al., 2023; Farber, 2019;

Baghdadi & Ismaile, 2018) which affects the preparation of students to deliver culturally sensitive care. Majnoon et al. (2023) found that educators rated themselves highly on scores of cultural awareness but lower on cultural skills and interactions, which shows a gap in translating these skills into practice. The study recommended that nurse educators improve their cultural competence skills by attending courses designed to facilitate interactions with other cultures. In a scoping review, El-Messoudi et al. (2023) also acknowledge that continuous development of cultural competence in healthcare is crucial to meet the demands of diverse global communities, especially in Spanish-speaking countries. They emphasise the need to develop a global consensus in higher education and continuous professional initiatives to standardise the cultural competence training of nurses.

The cultivation of high levels of cultural competence skills among nurse educators is paramount to providing culturally sensitive care (Paric et al., 2021; Chen et al., 2018; Marzilli, 2016; Montenery et al., 2013; Flood & Commendador, 2016). In a recent phenomenological study, Antón-Solanas et al. (2021) examined nurse lecturers' experiences and perceptions of teaching cultural competence in a four-year undergraduate nursing program. The study noted that nurse educators worked through the lens of different conceptualizations of culture, which influenced how they taught students. Some of the participants prioritised race and ethnicity as core elements of culture, while most included additional facets such as sexual orientation, occupation, age, and religion in their definitions (Antón-Solanas et al., 2021). On a positive note, they found that educators were aware of the influence of their cultural backgrounds on their teaching, particularly in multicultural classrooms. This prompted them to adapt their teaching methodologies to meet the needs of diverse students in their classrooms. They were also aware of prevailing social and political structures within healthcare systems that perpetuated social biases and discriminatory attitudes. Nonetheless, participating educators also identified limitations in their practice relating to confidence, knowledge, and skill set, emphasising a need for further education (Antón-Solanas et al., 2021).

Paric et al. (2021) found that in their practice, educators lacked adequate training and were challenged to articulate a definition of cultural competence. Similar to Antón-Solanas et al. (2021), this study found that nurse educators' inadequate levels of cultural competence significantly influenced how they integrated its core principles into their practice (Paric et al., 2021). However, both studies did note that nurse educators made efforts to incorporate cultural diversity in their practice often without the use of identified strategies to guide their teaching (Paric et al., 2021; Antón-Solanas et al., 2021). This indicates that although participants recognised the need to promote cultural diversity, they tended to regard it as an add-on to their practice and not as an

integral component. Both studies recommend that educators require the provision of formal training opportunities to empower them to improve their knowledge and skills, thereby facilitating effective cultural competence integration into their practice. In a more recent study, Rahimi et al. (2023) utilised a randomised control trial to assess the impact of a virtual training program in enhancing the cultural competence levels of nurse educators. Participants reported a marked improvement in their cultural competence knowledge and skill, which enabled them to act as proficient role models in fostering more culturally sensitive and inclusive care in the clinical area. These results are positive in emphasising the significance of further education on developing cultural competence in nurse educators, which can ultimately promote its practice in faculties.

The global discourse on diversity, equity, and inclusion (DEI) in nursing education resonates with the current landscape in Ireland. In the Irish context, Markey and Okantey (2019) also reiterate the need for cultural competence skills to be prioritised as a graduate capability in nursing. They emphasise the necessity to develop cultural competence in undergraduate nursing using a values-based learning approach. Educators and students need to recognise that cultivating professional values, can positively contribute to the delivery of safe care, shape their professional identity, and improve engagement with clinical decision-making (Ferrillo, 2020; Nelwati & Chong, 2019; Schmidt & McArthur, 2018). Markey and Okantey (2019) suggest that nurse educators need to rethink educational pedagogies, philosophies, and methodologies, that embody the values required to deliver culturally sensitive care, including care, commitment, compassion, communication, courage, and competence. For this learning to occur, nurse educators need to demonstrate a capacity for modelling culturally sensitive behaviours, integrate transformative pedagogies, and ensure they possess high levels of cultural competency skills. Therefore, educators need to guarantee that they are self-aware practitioners who can critically reflect on their positions as an essential component of integrating cultural competence into their practice (Paric et al., 2021). There is a paucity of research in examining nurse educator's role and strategies to teach ethical and value-based principles in terms of meeting the needs of diverse patients. Markey and Okantey (2019) suggest that educational strategies must go beyond merely incorporating value-based statements and instead embed values into the nursing curricula. Markey (2020) suggests that moral reasoning is central to the development of cultural competence in nursing. This can ensure that conceptualisations of cultural competence in nurse education can address current reports of culturally insensitive care in healthcare settings. Markey (2020) suggests that educators need to provide opportunities for critical reflection and offer inclusive learning environments to ensure that professional values are strengthened in cultivating cultural competence.

Existing literature continues to highlight the need for more training to enhance nurse educators' knowledge (Rahimi et al., 2023; Paric et al., 2021; Antón-Solanas et al., 2021) and to equip them with the skills to teach cultural competence (Marzilli, 2016). Marzilli (2016) also found a link between nurse educators' understanding of culture and their perceptions of the knowledge and skills required to provide care to culturally diverse populations. This study also reported a need for nurse educators to develop cultural competence skills through ongoing professional development activities. In a systematic review by O'Brien et al. (2021), nurse educators were shown to struggle with teaching cultural competence despite the significant responsibility of ensuring that students developed the skills, knowledge, and attributes to care for diverse patients. These studies highlight the need for educators to focus on improving their skills, reviewing their practices, engaging in continuous development, and considering transformative pedagogies to advance this practice. The authors argue that for Ireland to match the standards of their international counterparts, it is crucial for nurse educators and faculties to adopt similar strategies. This includes integrating comprehensive cultural competence training programs, fostering an inclusive learning environment, and prioritizing continuous professional development for educators to effectively prepare nursing students for the global healthcare landscape.

3.5 Integrating Cultural Humility into Nurse Education Practice

While other disciplines have explored the potential benefits of cultural humility in healthcare, there still exists a gap in the investigation within nursing literature. Foronda et al. (2016) conducted a systematic review of scholarly articles and highlighted the potential advantages of cultural humility in nursing practice. This was a particularly relevant exploration addressing the lack of investigation of cultural humility in the nursing literature. The review highlights that the practice of cultural humility includes the ability to self-reflect, question, and immerse oneself in another individual's point of view through active listening and accepting behaviours while serving to challenge personal bias (Foronda et al., 2016; Chang et al., 2012; Yeager & Bauer-Wu, 2013). Nurse educators need to cultivate learning environments that promote the examination of prejudices, beliefs, and biases, and an appreciation of the cultural practices of diverse individuals regarding healthcare outcomes (Foronda et al., 2022). Therefore, by embracing the principles of cultural humility into their practice nurse educators can significantly enhance student nurses' abilities to deliver culturally responsive and sensitive care. According to Smith et al. (2023, p. 2), nurse educators who incorporate DEI principles in their teaching, are better positioned to set positive examples for students. In particular, they believe that those who embrace cultural humility in their practice are more equipped to support their students in providing essential care to diverse patients in complex settings.

According to Fahlberg et al. (2016, p. 14), practicing cultural humility enhances cultural encounters by fostering respect for the decisions of patients and their families. Their study found that adopting cultural humility improved interactions by promoting mutual respect and understanding within cultural contexts. Kamau-Small et al. (2015) examined 149 nursing students who participated in an interactive workshop on cultural humility and care equity. Their findings showed that developing cultural humility skills led to positive changes in students' behavior during patient interactions. Similarly, Sedgwick and Atthill (2019) used interpretive phenomenological analysis to explore students' reflections on global health service learning (GHSL) and its impact on cultural humility and intercultural relationships. Despite facing barriers such as language and cultural differences, students reported gaining a deeper appreciation for diversity and the importance of self-awareness in cultural care. They developed skills in cultural humility that allowed them to challenge biases and ethnocentric views, facilitating meaningful intercultural relationships with patients. This suggests that promoting cultural humility among students can enhance their learning and understanding of cultural diversity and similarities.

However, there is a notable lack of Irish-specific research on supporting quality learning in diverse settings, despite terms like ‘super diversity’ and ‘commonplace diversity’ describing the increasing cultural complexity (Markey et al., 2023: 2). Markey et al. (2023) emphasize the importance of adopting culturally responsive pedagogies to promote intercultural integration and inclusiveness within culturally diverse learning environments. Their study underscores the critical role of educators in integrating these pedagogies into practice and promoting cultural awareness among students. Educators play a crucial role in incorporating cultural knowledge into teaching approaches, essential for managing intercultural relationships and exploring global perspectives. However, the study identifies challenges faced by teaching faculty in aligning their actions with the principles of culturally responsive pedagogy, often due to inadequate preparation for evolving culturally diverse environments. In this context, cultural humility can be beneficial as it requires nurse educators to develop an approach that involves "mutual understanding and awareness of the self in relation to others" (Ortega & Faller, 2011, p. 35). Douglas et al. (2014, p. 112) suggest that self-awareness is the initial step in understanding one's own and others' cultural values, traditions, and beliefs. Developing self-awareness empowers educators to recognize potential conflicts in values and beliefs that may hinder interactions with diverse groups, both in classroom and clinical settings.

However, achieving self-awareness is a challenging journey that requires practitioners to acknowledge personal biases, values, attitudes, and assumptions through reflection, evaluation, and critique (Hook et al., 2016; Tervalon & Murray-García, 1998). Cultural humility involves deep

reflection on oneself in interactions with diverse individuals, fostering respectful partnerships, mutual empowerment, high standards of care, and lifelong learning (Foronda et al., 2016, p. 213). Eckroth-Bucher (2010) emphasizes the importance of introspection, lifelong self-reflection, and examination of personal views and perspectives in developing self-awareness.

Practicing cultural humility requires educators to develop self-awareness of their own cultural biases, assumptions, and prejudices before demonstrating cultural humility to their students. Rasheed et al. (2019, p. 763) suggest that cultivating self-awareness allows nurses to recognize their thoughts, feelings, strengths, limitations, biases, and emotional states in practice. Enhanced self-awareness promotes deeper understandings of oneself, the environment, and contextual factors in nursing practice, contributing to the development of more competent practitioners.

Eckroth-Bucher (2010) further argues that self-awareness plays a crucial role in preventing practitioners from imposing personal biases, values, and prejudices on patients and others. However, Ortega and Faller (2011) highlight practitioners' difficulty in acquiring sufficient self-awareness and respect for diverse perspectives when integrating cultural humility into child welfare services. Therefore, while self-awareness is beneficial, its complexity must be understood in fostering cultural humility, particularly within educational contexts like nurse education.

Although research guiding nurse educators through the process of integrating cultural humility into their practice is limited, the literature offers some advice. Hughes et al. (2020) advocate for workshops and reflective spaces for students and educators to discuss and develop policies to integrate cultural humility into nurse education. According to Zinan (2021, p. 4, 5), there are key areas that warrant consideration when integrating cultural humility into nurse education. To personally engage with cultural humility, educators are advised to adopt a critical questioning role, practice self–reflection, value other opinions, actively listen, and promote self-growth. By embedding cultural humility in their philosophy, organisations and leaders can help to support and motivate educators through meaningful collaboration on cultural diversity. Establishing policies that foster humility is crucial for promoting equity and developing new practice paradigms (Zinan, 2021, p. 4, 5). Ginsberg and Mayfield-Clark (2021) also emphasise the significance of developing mechanisms that encourage students and educators to recognize personal biases and shared learning opportunities to foster the development of deeper respect and acceptance for other cultures.

Hughes et al. (2020) propose that cultural humility should be integrated into nurse education at three levels; intrapersonal, interpersonal, and systemic. Foronda et al. (2022; 2) present a cultural humility toolkit that recommends the introduction of teaching and integration strategies from the

early stages, specifically designed for faculties considering the inclusion of this concept into their nursing programs. To effectively integrate cultural humility into nurse education, it is crucial for educators to foster inclusive learning environments that promote respect for differences within the classroom setting (Foronda et al., 2022; Chen et al., 2018). This approach will create safe spaces for students and educators to openly discuss and address any biases they may bring to their cultural encounters. At a management level, there needs to be a commitment to providing time and space for individual self-reflection, discussions with colleagues and communities, and participation in the development of cultural humility policies (Foronda et al., 2022). According to Fisher-Borne et al. (2015), integrating cultural humility into teaching practice requires nurse educators and faculties to be accountable for their practice of cultural diversity, ensuring a commitment to lifelong self-reflection and critique (Tervalon & Murray-García, 1998, p. 117). This responsibility extends to all stakeholders, particularly nurses, who must develop skills to examine personal biases and assumptions that could influence their teaching. By promoting cultural humility, healthcare institutions can strive towards non-discrimination and equality, aligning with the principles of inclusive patient care and equitable treatment.

3.6 Nurse Educator's Role in Examining Bias

A core tenet of cultural humility places responsibility on the practitioner to reflect on their values, beliefs, and potential biases, often hidden but significantly influential in their daily healthcare practice. Hughes et al. (2020, p. 29) suggest that unconscious bias extends beyond race to age, gender, sexual preference, mental health, learning difficulties, immigration status, and religious identity. Tervalon & Murray-García (2011, p. 32) proposed cultural humility as an ongoing process for healthcare practitioners to examine their biases and assess how these factors can influence their patient care. Markey et al. (2021, p. 2726) suggest that critically examining individual beliefs about cultural differences can challenge the practice of 'othering,' which is detrimental to the building of respectful relationships in healthcare. This literature review will briefly examine incidences of bias in nursing and healthcare practice to highlight how important it is for healthcare workers to recognise its presence and understand its effect on patient care.

Blair et al. (2011, p. 71) report a decrease in explicit bias in society, but maintain that implicit bias persists, often functioning unconsciously. As a result, they believe that implicit bias is a contributing factor in persistent health disparities across diverse groups, as it comprises unfavourable comparisons of one's own culture over another, which is primarily influenced by cultural cues such as reactions to skin colour. They contend that in healthcare settings, implicit bias occurs in incidences where certain populations are perceived in terms of compliance, personality traits, and socioeconomic status. These negative perceptions can result in poor

therapeutic relationships, significantly impacting the patients' treatment decisions and collaboration with healthcare goals (Blair et al., 2011, p. 72). In an Irish study, McGorrian et al. (2012), found that members of the travelling community experienced more health problems in comparison to the general population. They also noted that this diverse group reported poorer outcomes in healthcare settings. Quirke et al. (2022) report that the travelling community in Ireland experiences more discrimination across many fields of society, including housing, education, and employment. Attitudes toward travellers from settled communities remain low, with 64% of healthcare workers indicating that they would judge this diverse group based on their lifestyle choices (MacGreil, 2010). According to a study by Quirke et al. (2022), the life expectancy of travellers was found to be comparable to that of settled communities in 1945. They reported that male travelers have an average life expectancy 10 years shorter than their counterparts in settled communities, while female travelers have a life expectancy 12 years shorter. This is concerning, as Fitzgerald and Hurst (2017, p. 2) argue that negatively evaluating group attributes can influence cultural encounters, patients' healthcare outcomes, and the delivery of quality care. Blair et al. (2011) urge practitioners to continually reflect on their biases to reduce their impact on patient healthcare outcomes. Zestcott et al. (2016) believe that implicit bias is an increasing concern in health care, especially given its continued relationship to health disparities. Therefore, an examination of how implicit bias manifests in healthcare can strengthen practitioner's resolve to find ways to address it.

A correlation between health inequalities and insufficient patient outcomes has also been established in the literature, as a result of gender bias. A recent report found that black women were up to four times more likely to suffer pregnancy-related complications leading to death, in comparison to their Caucasian counterparts (CDC, 2020). In another study, care of patients of African descent, especially women, was found to have a higher risk in poor healthcare outcomes in healthcare settings (Howell et al., 2016). This study found that black women were limited in their choice of hospital for maternity care, leading to an increased risk for maternal deaths. Similarly, the CDC (2020), reported a differential between black infants at 10.9 per 1000 births, compared to white births at 4.9, revealing a notable 2.2-fold difference between the two groups. Maina et al. (2018) conducted a systematic review to examine the presence of implicit bias among healthcare workers. The majority of the studies reported more instances of implicit bias towards patients with darker skin tones, with black practitioners demonstrating fewer signs of implicit bias than their white colleagues. Westergaard et al. (2019) conducted a large study in Denmark, examining health data from 7 million men and women over 21 years. They found that women experienced delayed diagnoses across a spectrum of 700 diseases compared to men. This

highlights a significant issue that must be addressed to ensure that women accessing healthcare receive evidence-based care equal to that of men.

In a theory-guided literature review, Samulowitz et al. (2018) identified differences in how pain is perceived, expressed, and coped with between male and female individuals. The study highlighted the presence of hegemonic masculinity and andronormativity, which led to societal stereotypes regarding pain experiences across genders. According to the studies reviewed, men were seen to be stoic and in control of their responses to pain while women were perceived as being more sensitive or even hysterical. The studies also indicated that conditions primarily experienced by women, where pain is the primary symptom, were perceived as having lower priority in the medical hierarchy. These differences were not perceived to be attributed to biological differences but societal norms. Greenwood et al. (2018) examined gender disparities in survival rates following acute myocardial infarctions, revealing significant differences in approaches to physician care. The study reported that both male and female genders had similar outcomes when treated by female physicians. However, under the treatment of male physicians, the largest cohort of practitioners, female patients had a lower rate of survival. This variance improved when male physicians were exposed to female patients or colleagues, thereby reducing their apparent discomfort with treating female patients. These studies indicate a need for more efforts to adopt strategies to improve gender disparities in healthcare.

Fitzgerald and Hurst (2017) conducted a systematic review that reported implicit biases across a spectrum of factors including, age, weight, mental illness, gender, race and ethnicity, intravenous drug abuse, and poor socioeconomic status. The presence of this bias in both physicians and nurses was also shown to have a direct correlation to quality care provided in healthcare settings. They conclude that there is a need for greater awareness of bias in healthcare and further examination of its relationship to patient care and cultural interactions. An example is provided by Bachmann and Gooch (2018), who conducted a collaborative study with YouGov, and reported that a quarter of the lesbian, gay, bisexual, and transgender (LGBT) community surveyed regularly face poor understanding of their healthcare needs. The report indicates that one in four members of this diverse group has been subjected to negative remarks about their LGBT identity while accessing healthcare services. The report also found that one in eight participants have received inequitable treatment and one in seven avoid healthcare treatment for fear of facing discrimination. The authors recommend that nurse educators develop approaches in their educational initiatives that are more reflective of trans-inclusive care, and suggest that healthcare curricula need to become more inclusive of homophobic, biphobic, and transphobic language and their potential to perpetuate discrimination in practice.

In a global world survey, the WHO (2016) found negative attitudes in terms of ageism and discrimination present in healthcare systems. This has a detrimental effect on elderly patients' quality of life and general mental health. These poor outcomes were also reported in a recent systematic review examining the effect of structural and individual ageism on older patients' health (Chang et al., 2020). This review recommended that ageism requires greater focus in healthcare and needs to be considered as a social determinant of health. Another study found that nurses often excluded elderly patients from decisions about nutrition in their care plans (Sjögren Forss et al., 2018). This study reported on nurses' tendency to issue instructions about nutritional supplemental drinks, without any conversations with the patients about their personal preferences. Hunter and Dahlke (2023) believe that ageism is common in nursing, with nurses often holding the belief that elderly patients are incapable of making their own decisions. This can result in poor person-centred care for elderly patients, which often fails to regard their specific needs and preferences. Ageism is also reported as being problematic by other sources (Shpakou et al., 2021; Abdou et al., 2016), with up to 50% of participants in one study reporting that discrimination against the elderly in healthcare is a significant social problem (Shpakou et al., 2021). Healthcare stigmatisation and discrimination have also been reported in cases of obesity (Puhl et al., 2016), homelessness (Campbell et al., 2015), mental health issues (Merino et al., 2018), and the immigrant population (Hacker et al., 2015).

Hunter and Dahlke (2023) state that nurses often use binary language in their practice to expedite caregiving in busy environments. This practice of categorical thinking in nursing practice is viewed as essential for quick decision-making and prioritisation of care. Drawing on Kahneman's (2011) work they assert that nurses often use terms to describe patients such as heavy/light, confused or orientated, incontinent, or continent when engaging with fast thinking that can facilitate rapid decision-making. An outcome of adopting these preconceived labels is poor interpretations of patient needs and the imposition of unconscious bias in patient care. The authors advocate for nurse educators to use self-reflection as a tool to address their personal biases to improve quality patient care. The principles of cultural humility can expand healthcare professionals' limited worldview of different cultures, challenge their bias, and address their influence on patient care. Developing interpersonal cultural humility relies on practitioners' understanding and questioning of cultural beliefs and values inherent in the cultures they serve (Hughes et al., 2020). Open and respectful intercultural encounters thrive on self-reflective intrapersonal skills (Hughes et al., 2020) and interaction with interpersonal cultural humility. Hughes et al. (2020, p. 29) recommend self-reflection and examination of unconscious bias as strategies to promote the intrapersonal aspects of cultural humility, ultimately enhancing interpersonal relationships through openness and respect. Markey et al. (2023), in their Irish study,

explore implicit biases among students and faculty to enhance intercultural engagement and integration within diverse learning environments. They demonstrate how unaddressed biases can hinder such engagement, leading to exclusionary behaviors and tensions within groups. The findings emphasize the need to broaden perspectives on cultural differences and implement clear intercultural learning goals to foster mutual understanding and respect. According to Wright et al. (2021) and Ochs (2023), nurses need to critically examine their practice and embrace new discourses if it is to be successfully integrated into practice. This dynamic approach can foster more inclusive, equitable, and culturally sensitive care to diverse patients.

3.7 Exploring Dominant Narratives in Nurse Education

Nursing scholars are urging a reconsideration of nursing discourses that perpetuate discourse and narratives that hinder the progression of the nursing profession (Holmes et al., 2008; Reimer et al., 2007). This initiative is crucial to undertake if nursing professionals are to prevent dominant discourses from 'defining the margins of acceptability as well as who falls outside those margins' (Merryfeather & Bruce, 2014, p. 112). Browne (2001) asserts that nurse education has traditionally been influenced throughout history by ideologies structured and driven by racialisation, power dynamics, patriarchy, heteronormative assumptions, and neoliberalism. Such discourses have continued to shape student nurses' social, political, and cultural assumptions, significantly influencing how they perceive diversity and privilege in their practice (Lapum et al., 2022). Blanchet-Garneau et al. (2019) explored the impact of dominant discourses on a Canadian unit that practiced equity-oriented healthcare. They examined discourses such as racialisation, egalitarianism, biomedical efficiency and culturalist, in terms of how they reinforce, challenge, or influence healthcare practices in the unit. In reviewing the impact of culturalist and racialisation discourses on diversity, they were concerned about their tendency to perpetuate stereotyping and inequities in healthcare. They also found that these prevailing discourses reduce cultural sensitivity and communication in cultural encounters which leads to inequitable care. A primary reason for this is that these discourses often overlook systemic discrimination, resource accessibility, and socioeconomic factors that influence healthcare outcomes.

Biomedicine is a prevailing discourse that has significantly impacted the development of nursing knowledge and practices in the past few decades (Blanchet-Garneau et al., 2019; Holmes et al., 2008). Holmes et al. (2008, p. 42) states that the biomedical ideology has historically served as colonial patronage, on knowledge creation, dominant discourses, current policies, and nursing practice. The biomedical model represents a view of disease and illness as dysfunctions of body systems that are related to specific pathogens. The biomedical model perceives patients as entities consisting of distinct systems which has sustained the hierarchical relationship between medical

practitioners and their patients (Fawcett, 2017). Therefore, the patient is seen through a reductionist lens which often neglects other holistic factors that influence patient care. The underlying foundation of biomedical theories is rooted in empiricism and positivism, emphasising verification, control, observation, reduction, and objectivity in the generation of knowledge (McEwen & Wills, 2014). According to Horrill et al. (2018), the medical model has been dominant in how nursing scholars define their profession, build nursing knowledge, and determine access to healthcare delivery. Its primary focus was on a patient's biological issues, which could be treated independently of psychological and social issues. According to Thurman & Pfitzinger-Lippe (2017), nursing metaparadigms are closely aligned with the biomedical model, marginalising issues of social justice, equality, and other societal elements that need to be integral to nursing care. Drevdahl (2018) believes that recognition of how colonial systems and discourses contributed to systematic healthcare inequities are needed to develop creative approaches to improving healthcare for marginalised groups.

Dillard-Wright and Gazaway (2021) recognise the need to challenge current discourses in health care, concerned with diversity, equity, and inclusion in the wake of the Covid-19 pandemic. They suggest that dominant discourses in nursing have sustained limited perspectives on culture which has impeded the progress of social justice issues in education. They aim to promote discourses encouraging more engagement with ongoing issues of power, privilege, health equity, oppression, and justice in healthcare. In this endeavour, they critiqued current narratives in nursing textbooks and literature that sustain social injustice practices that marginalise diverse populations. This prompted them to challenge the competency tick box system when teaching diversity and to recognise implicit bias in educational resources serving as the hidden curriculum. Grenier (2020) suggests that models such as cultural competence have perpetuated white supremacy in healthcare systems, calling for nurse education to adopt critical frameworks in their curricula and to recognise and address narratives perpetuating oppression (Grenier, 2020). Valderama-Wallace & Apesoa-Varano (2019) suggest that nursing faculties and scholars need to address the historical presence of whiteness and emphasise justice issues in their curricula. As part of this challenge, Bell (2021) and Coleman (2020) suggest that nurse educators need to foster anti-oppressive and anti-racist strategies in their educational strategies. Indeed, Bell (2021) is critical of nurse education's lack of engagement with critical analysis of race issues and the origins of oppression in the pursuit of recognising marginalised voices. Lapum et al. (2022, p. 116) believe current discourses have reproduced systems of 'oppression, racism, sexism, and ableism', particularly in the nursing literature. Their study advocates for the use of open educational resources to counteract the dominant discourses in nursing literature that is shaping how cultural diversity is practiced in nursing faculties. Their study promotes the design of educational resources that offer both visual

and textual evidence of diversity to promote inclusivity and social justice in nurse education. However, Iheduru-Anderson (2020) recognises that addressing the culture of whiteness in nurse education can be difficult as it can provoke negative reactions from many white clinicians, academics, and students. According to Waite and Nardi (2019, p. 20), this unwillingness to explore new pedagogies addressing oppression has led to a 'collective denial and culture of silence'. To date, Wright et al. (2021) contend that nurse educators have failed to engage in meaningful discussions about oppression and privilege, limiting their capacity to question ethnocentric practices and integrate inclusivity into their approaches. Nonetheless, Murray and Noone (2022) call for the decolonisation of nurse education and curricula, advocating for a reassessment of the Eurocentric lens that guides the discipline. O'Brien et al. (2019) remind us that nurse educators need to address other ethnocentric ideologies to promote authentic engagement and effective learning.

Nursing practice is guided by approaches to care that are designed to promote individualised, patient-centred, or person-centred care. The terms are used interchangeably to describe care delivery, but patient and person centred are the more prevalent terminology in the literature. Zhao et al. (2016) state that although both models can often seem synonymous, their implications can differ leading to varying understandings of care in the healthcare setting. Nonetheless, they represent the dominant discourse in guiding the daily work of care delivered to a patient. According to Godfrey et al. (2018), individualised care is the term used in clinical areas to convey how nurses perceive and aspire to deliver person centred care, and is synonymous with a high standard of quality care delivery. Individualised care endorses a holistic approach to care, which represents the distinct differences that involve a patient's, personal circumstances, medical state, and independence in decision-making (Suhonen & Charalambous, 2018). However, Godfrey et al. (2018) note that nurses did not differentiate between the terms but were more inclined to use the term individualised care before accessing formal training.

Johnson et al. (2018) describe both approaches as having the fundamental characteristics that recognise that the patient is core to their care, respecting their values, beliefs, and preferences as part of the healthcare journey. Patient-centred care strives to consider the patient as a partner in healthcare decisions but primarily prioritises the functional aspects of caregiving. However, the term is currently used sparingly as it is criticised for not paying due attention to the holistic nature of nursing care (Håkansson Eklund et al., 2019). Kelsall-Knight (2022) states that patient-centred care tends to represent the patient as a submissive to the physician when undergoing a medical condition or intervention. This traditional power dynamic can side-line the patient from the decision-making and overlook their values, beliefs, and cultural backgrounds in care planning

(Kelsall-Knight, 2022). This has significant implications for the delivery of culturally responsive and sensitive care for diverse patients. Zhao et al. (2016) believe that patient-centred care has been used synonymously with cultural competence which challenges healthcare workers to holistically view patients when their focus is on a specific illness. As a result, person-centred care began to appear more in the literature to describe care that adopts a broader approach to patient care and diversity.

According to Mathers & Bansal (2016), approaches that emphasise knowledge as a primary educational requirement, such as patient care models and cultural competence, do not address the complexities of diversity in healthcare. Mathers and Bansal (2016, p. 2) emphasise that medical education has favoured a traditional educational approach to cross-cultural education, which focuses on obtaining factual information about diverse groups of patients. This may account for the shift to the term person-centred care as it considers the patient's personal background, family dynamics, and unique perspectives in care planning. Person-centred approaches advocate for empowering the patient in their care decisions as opposed to viewing them as passive recipients in healthcare (Håkansson Eklund et al., 2019). Mathers and Bansal (2016) embrace person-centred care (PCC) for its inclusivity of patients' perspectives, especially in cultural encounters with practitioners during the diagnostic and intervention phases of care. Cultural humility can improve the practice of PCC by emphasising the importance of self-awareness and respect as the cornerstone of practitioner practice (Betancourt, 2006). Ortega and Faller (2011, p. 30) believe that cultural humility can play a pivotal role in addressing the complexities of diversity, embracing multiple perspectives on cultural differences and identity, and critically examining power dynamics that perpetuate continuing practices in healthcare. Therefore, it can offer nurse educators strategies to strengthen DEI in their articulation of PCC models, both in their practice and in the philosophy of nursing faculties, to promote culturally responsive and inclusive care.

3.8 Culturally Responsive Nursing Education

The need to develop intercultural inclusive learning environments is fundamental to the practice of cultural diversity in nurse education (Markey et al., 2021) requiring several considerations for nurse educators. According to Markey et al. (2021), in the Irish context, strategies aimed at promoting inclusivity in nurse education require sensitive facilitation to enable students to learn about cultural identity and differences. This emphasis on sensitive facilitation resonates not only within Ireland but also internationally, highlighting the universal importance of addressing cultural diversity in nursing education. There seems to be uniform agreement that students need to be able to share diverse perspectives, experiences, cultural differences, similarities, and norms (Markey et al., 2020; Markey et al., 2021; Day & Beard, 2019) to develop their skills and to avoid reinforcing

discriminatory practices in healthcare (Almutairi et al., 2017). According to Sloane and Petra (2021), nurse educators need to foster brave environments to encourage students to explore personal biases, assumptions, and personal identities. They argue that the word brave is synonymous with personal growth and learning and is a more apt term to use when having difficult discussions on bias and promoting empathy. According to Abdul-Raheem (2018), the nurse educator needs to establish an interest in students' cultural backgrounds to develop their skills to care for diverse patients. As facilitators of diversity learning, nurse educators must be sensitive to language bias and accommodate divergent communication styles inherent in cultural and linguistic backgrounds (Sommer et al., 2019; Markey et al., 2021). This includes remaining attentive to possible cultural misunderstandings and misrepresentations and the potential for racism in the classroom environment (Markey et al., 2021). If nurse educators are to adopt cultural humility initiatives in their teaching they need to employ methods that build self-awareness, initiate discussions on marginalised patients, and focus attention on issues of social injustice (Fisher-Borne et al., 2015; Foronda et al., 2016; Mosher et al., 2017).

Solchanyk et al. (2021, p. 3, 4), posit that nurse educators need to provide safe spaces to allow students to explore their own cultural identity, discuss differences, address sensitive emotions, and articulate divergent opinions. These endeavours require the educator to be proficient in managing healthy discussions on cultural diversity while navigating differing perspectives that emerge in the classroom. One strategy to ensure that nurse educators promote safe and respectful discussion is to provide clear ground rules for students in positive learning environments (Smith & Foronda, 2021, p. 2). This is particularly important when integrating the principles of cultural humility such as personal examination of biases, assumptions, and personal identities. They suggest that nurse educators need to facilitate honest dialogues about differences in respectful classroom settings. They also suggest that through modelling and promoting diversity values in the classroom, nurse educators can promote an appreciation and tolerance of diversity. Smith and Foronda (2021) believe that this is particularly important when discussing personal differences of identity including, ethnic and racial backgrounds, religious beliefs, gender influences, and sexual orientation. It is also important that the educator takes time to avoid reinforcing previously held assumptions or prejudices (Almutairi et al., 2017) by exploring similarities and promoting an understanding of cultural differences (Markey et al., 2021). Sommer et al. (2019) believe that fostering safe spaces for discussions on diversity and employing strategies that avoid language bias is also essential. These initiatives can help create empowering, inclusive, and supportive environments that will accommodate learning about diversity and integrating cultural humility in nurse education. Markey et al. (2023) emphasize the pivotal role of the teaching faculty in fostering intercultural dialogue and maximizing learning opportunities across cultural boundaries within an

Irish context. Their study also addresses the importance of acknowledging and addressing subtle nuances of superiority and inferiority in classroom dynamics to create inclusive learning environments that value cultural diversity and promote engagement across cultural boundaries.

Nurse educators need to focus on adopting strategies that encourage students to explore different perspectives and pay attention to healthcare disparities and social determinants of health (NLN, 2019). Markey et al. (2021) propose from an Irish perspective that nurse educators need to find strategies to encourage students to examine their own beliefs and values, from personal, cultural, and professional perspectives. In particular, these strategies need to provide opportunities for students to examine personal bias and their potential impact on patient care. The examination of bias through the lens of individual cultural norms and differences can promote respect for cultural diversity (Markey et al., 2021). Recognising and addressing bias is an essential component of cultivating a future workforce that is culturally aware and sensitive to the diverse needs of patients (Kidd et al., (2022). Their cross-sectional study demonstrated the need for consistent educational initiatives aimed at recognising and addressing bias that can promote long-term behavioural change in the healthcare workforce. Sukhera and Watling (2018) propose a six-point framework for educators to guide them in the inclusion of implicit bias training in their programs. They suggest that educators need to design strategies that will encourage the development of knowledge on implicit bias and its effects on others, enhance self-awareness, create inclusive environments, and improve personal levels of consciousness that will address bias. Hudiburg et al. (2015) also emphasised the need to recognise and understand student diversity as a way to promote cultural diversity in educational settings. MacDaniel (2020) suggests that incorporating cultural humility in future approaches is an effective way to ensure that these criteria are met for future practice. However, there is a recognition that a requirement for nurse educators to fulfill this component of their role they need to assess their teaching strategies and practices (Foronda et al., 2022, p. 268) to ensure they will foster critical thinking, thereby boosting students' confidence (Meier, 2013; Corrigan-Magaldi et al., 2014).

3.9 Teaching Strategies

Developing and implementing teaching strategies that respond to cultural diversity and incorporate cultural humility is essential to preparing students to deliver culturally sensitive care. However, engaging with inclusive intercultural learning can present challenges for the educator (Day & Beard, 2019; O'Brien et al., 2019). Simulation, with patient scenarios is highlighted as a significant positive strategy in the drive to increase the cultural competence of nursing students (Qin & Chaimongkol, 2021; Ozkara, 2019; Ndiwane et al., 2017), particularly from a cognitive, practical, and affective learning perspective (Ozkara, 2019). Ozkara (2019) found that following simulation

exercises, participants were more confident in terms of their attitude towards the care of diverse patients, as compared to their overall transcultural knowledge base. Isaacson (2014) also felt that simulation could be a useful tool to develop cultural humility in student nurses. Foronda and Mac Williams (2015) highlighted that teaching cultural humility in simulation was a missing standard in nursing education.

Simulation instruction on cultural competence includes the need to provide nursing care through awareness, knowledge, and skills that are sensitive and congruent to diverse populations. Foronda and MacWilliams (2015) suggest that simulation could be a valid tool to challenge students to see beyond their values, cultural ideas, and lived experiences by reflecting on their backgrounds and recognising the diverse cultures of others. A simulation that has integrated issues of race has also received favourable reviews from diverse students (Fuselier et al., 2016). This study found that the use of coloured manikins helped students gain confidence and learn essential skills in caring for diverse patients. However, the study also reported that students did not regard the use of diverse manikins as realistic, which indicates an ambivalence about their colour.

Other studies have reported that simulation can develop student confidence when caring for patients from diverse backgrounds (Ndiwane et al., 2017; Everson et al., 2015). The effectiveness of using simulation in a medical program demonstrated that students' knowledge, skills, and attitudes to cultural diversity had improved (Smith & Silk, 2011) with virtual simulations demonstrating increased engagement with learning, from a myriad of health professionals and students (Luctkar-Flude et al., 2021; Foronda et al., 2017; McCoy et al., 2016). In particular, Luctkar-Flude et al. (2021) found it to be a valuable teaching and learning strategy that could promote self-reflection upon personal biases and assumptions related to gender identity and sex orientation. They found that using simulation to role-play intercultural encounters increased student awareness of how culture can influence the patient's healthcare journey. O'Brien et al. (2021) noted that it was important to use simulation for practice on cultural diversity but that their effectiveness was increased by using diverse patient scenarios, web-based supports, and opportunities to engage with intercultural encounters.

International immersion projects are highlighted as useful strategies to promote cultural competence in nursing students. Immersion programs can help students develop a greater understanding of different cultures because of exposure to differences in nursing practice, healthcare systems, and cultural values and beliefs (Kohlbry 2016; Browne et al., 2015; Amerson, 2014). It is recognised as a strategy that provides transformative learning experiences for the students, which can increase their cultural consciousness (Alexander-Ruff & Kinion, 2018; Thibeault, 2019) and reduce the risk of bias in their practice (Gradellini et al., 2021). Recent studies

also support the use of international immersion projects to facilitate a deeper cultural understanding and competence for the student (Gallagher et al., 2019; Jimenez & Thal, 2019) which encourages them to challenge their own bias (Alexander-Ruff & Ruff, 2021). McInally et al. (2015) studied learning opportunities for undergraduate nursing students through an immersion program between the U.S. and Scotland. Using a collaborative cultural learning model, four primary themes were identified; educational, cultural, collaborative, and clinical learning experiences. Students from both countries used reflective journals, for evaluation and found that they had gained a cultural appreciation with professional and personal growth, through the program. Elverson & Klawiter (2019) also provide some advice on how particular strategies need to be cultivated to ensure that cultural learning is achieved. The results of their project, which incorporated reflective exercises, showed an improvement in students' ability to think critically, allowing them to make meaningful connections between the concepts they learned, their experiences, and service-learning (Elverson & Klawiter, 2019, p. 185,186). The positive results led nurse educators to recommend the continuation of such programmes, but also to highlight the need to integrate models of cultural learning that continue to use self-assessment strategies of cultural competence and guided self-reflection in future programs. However, Matthews et al. (2021, p. 882) raised concerns about how these programs can be influenced by students' essentialist views of culture or their different understandings of cultural competence. Although their study was not specifically focused on cultural humility, it demonstrates that a central tenet of the concept, relating to reflection, can lead to a profound change in student learning regarding the care of diverse cultures.

According to Markey et al. (2021), developing intercultural discussion in the classroom is crucial to the creation of safe learning experiences for students. Discussion, as a teaching method, can develop students' critical thinking, confidence, and self-awareness which are essential to the understanding of diverse perspectives (Syafrizal & Pahamzah, 2020). However, facilitating discussion necessitates careful planning to develop approaches that respect all voices in the classroom (Markey et al., 2021; Sommers and Bonnel, 2020). Such initiatives require attention to the sensitive management of sharing personal perspectives and opinions (Markey et al., 2021) and ensuring that participants feel connected (O'Brien et al., 2019). Strategies to prevent dominant voices in the discussion, such as allowing individuals to speak in turn, can facilitate a sense of belonging for students, strengthening their contributions to discussions of cultural diversity (Abdul-Raheem, 2018). Moreover, Markey et al. (2020) believe that fostering shared learning and promoting active listening to diverse perspectives and cultural norms are instrumental in preparing students to care for diverse populations. Almutairi et al. (2017) suggest that educators should focus on similarities as opposed to differences if students are to learn how to avoid perpetuating

stereotypes in their practice. Sommer et al. (2019) believe that educators also need to limit incidences of language bias by being aware of how modes of communication, delivery, and content can contribute to creating inclusive environments. Day and Beard (2019) believe that using discussion in nurse education to facilitate the sharing of alternative perspectives can limit the presence of the dominant Western biomedical voice inherent in healthcare. To strengthen culturally responsive teaching, nurse educators need to facilitate group discussions that are collaborative, interactive, and responsive to different perspectives, while encouraging critical inquiry and challenging assumptions (Day & Beard, 2019). Nurse educators play a pivotal role in promoting culturally inclusive, non-judgmental environments where students feel comfortable engaging sensitively, ethically, and responsibly in discussions on cultural diversity (Markey et al., 2021; Jokikokko & Uitto, 2017). Before each classroom session, it is essential to establish ground rules, and discuss the use of terminology and modes of communication (Markey et al., 2021). Markey et al. (2021) advocate for a collaborative approach with service partners and faculty members when facilitating discussion in intercultural classrooms, which can promote strategies that encourage the sharing of personal experiences and reflections.

Recent literature emphasizes the pivotal role of innovative teaching strategies in nursing education to foster cultural sensitivity and inclusivity among students. These approaches aim to equip future healthcare professionals with the empathy and proficiency needed to navigate diverse patient populations effectively.

For example, Okenwa-Emegwa and Eriksson (2020) utilized role play to immerse students in simulated healthcare scenarios, encouraging them to adopt diverse perspectives and develop empathy towards patients from various cultural backgrounds. Their study demonstrated that this active learning method not only bolstered students' confidence in managing cultural diversity but also sharpened their communication and decision-making skills in challenging clinical situations. In another study, Gallagher and Stevens (2015) employed photo voice to promote cultural humility among nursing students. By engaging students in capturing and narrating visual representations of community health issues, this approach facilitated deep reflection and heightened self-awareness. Students gained valuable insights into the social determinants of health and developed a greater appreciation for the cultural diversity present within their patient populations. Loue (2018) advocated for the use of sociodrama in healthcare education to challenge stereotypes and biases. Through role-playing exercises that simulate real-life patient interactions, students were encouraged to confront their assumptions and prejudices, thereby fostering a nuanced understanding of cultural differences and enhancing their patient care approaches. Schuessler et al. (2012) highlighted the role of reflective journaling in complementing these active learning

strategies. By encouraging students to critically reflect on their clinical experiences through a cultural humility lens, this practice deepens their understanding of cultural competence and enhances their ability to provide patient-centered care that respects and responds to diverse cultural backgrounds. Furthermore, Burgess et al. (2017) proposed mindfulness training as a method to cultivate non-judgmental awareness and sensitivity in healthcare professionals. This practice equips students with the skills to navigate cultural encounters with openness and respect, promoting equitable care delivery across diverse patient demographics. In summary, these innovative pedagogical approaches enrich the educational experience of nursing students and empower them to become culturally competent healthcare providers. By integrating these strategies into nursing curricula, educators can effectively prepare students to address the complex and diverse needs of patient populations in today's global healthcare landscape.

However, despite these insights, while there is a plethora of literature advocating for the integration of diversity, equity, and inclusion (DEI) principles into nursing education (Markey et al., 2021, Wright et al., 2021, Cox 2023) there remains a significant gap in the discourse concerning innovative approaches to achieving these objectives. While studies from both global and Irish contexts emphasise the importance of addressing social determinants of health, health disparities, and cultural sensitivity in nurse education, there is limited exploration of novel pedagogical methods and educational strategies to effectively incorporate DEI principles into curricula. The existing literature predominantly focuses on the identification of deficiencies and the call for increased attention to DEI content, rather than offering concrete solutions or innovative practices. This gap underscores the need for future research to explore and evaluate innovative approaches that go beyond traditional teaching methods, such as simulation-based learning, immersive experiences, and technology-enhanced education, to foster cultural competence and inclusivity in nursing education.

3.10 Student Diversity

As part of initiatives to promote inclusivity, Markey et al. (2021) have also emphasised the need for nurse educators to consider the diverse learning needs of their students within the classroom environment. According to Mikkonen et al. (2016), diverse students have to face many obstacles in education including language and communication issues with faculty, other healthcare providers, and patients (Crawford & Candlin, 2013). These cultural issues can prompt nurse educators to adapt and develop strategies to address issues of cultural diversity in the classroom to ensure inclusivity in learning (Sommers, 2020). To be authentically inclusive in their practice nurse educators need to be responsive to diversity within a class to ensure that differences are nurtured rather than merely tolerated (AACN, 2017). Therefore, nurse educators need to take

responsibility for fostering trusting and sensitive interactions between diverse students and educators within the classroom setting (Jokikokko & Uitto, 2017). These approaches can cultivate an awareness of cultural diversity in the classroom which can enhance student's practice in the clinical area and provide educational approaches that cater to their individual and collective learning requirements. Miller and Vaughan (2023) found in their study that Black and Hispanic students in a nursing program in the U.S. often felt they were singled out, treated differently, and experienced incidences of higher expectations, public criticism, and extra pressure due to their ethnicity. These feelings left them with feelins of low morale which affected their ability to interact and learn in the classroom. Miller and Vaughan (2023) recommended that nursing faculties need to make considerable efforts to address inclusivity with a focus on improving representation, integrating antiracist pedagogies, and prioritising diversity content in the curricula.

In an Irish study, Markey et al. (2019) reported that international postgraduate nursing students also experienced feelings of isolation, loneliness, and homesickness. The study recommended strengthened approaches to inclusivity by offering additional resources for cultural orientation, language, and student emotional well-being. By developing their understanding of student diversity, nurse educators can ensure that focus on cultural diversity originates in the classroom and extends to other educational forums and clinical areas. Moffitt and Durnford (2021) examined the establishment of initiatives to support cultural safety in classroom settings. Through the means of student research, responses were supportive of creating safe environments that allowed them to be courageous in engaging in open discussion, historical injustices, and the development of genuine relationships in shared learning. The study indicated that students had developed self-awareness and empathy while cultivating non-judgemental approaches to diverse perspectives.

3.11 Summary

The literature review has identified a significant research gap in the areas of cultural diversity, cultural humility, and inclusive nurse education, particularly within the Irish context. While global studies offer a broad perspective, there is a lack of innovative, context-specific research that addresses Ireland's unique cultural and socio-economic factors. This gap highlights the necessity for future studies that integrate local viewpoints and employ innovative methodologies, directing future research towards these needs.

In addition to this identified gap, it is crucial for future research to explore the integration of cultural diversity and cultural humility within person-centered care models. Person-centered care emphasizes tailoring healthcare delivery to meet the unique needs and preferences of each individual patient. However, there is a paucity of research examining how cultural diversity can be effectively integrated into person-centered care models within nursing education.

Furthermore, it is imperative to study and explore the dominant discourses that may impede the progress of cultural diversity integration in nurse education. These discourses can include entrenched beliefs, attitudes, and institutional structures that may perpetuate biases or hinder efforts to promote inclusivity and diversity within nursing education programs. Understanding and challenging these dominant discourses is essential for creating meaningful change and fostering a more inclusive educational environment for future nurses.

Inclusive education fosters environments where all students, regardless of background or identity, feel valued and respected. By studying inclusive education practices, nurse educators can gain insights into effective strategies for promoting cultural diversity and addressing barriers to inclusion within nursing education. To address these gaps, future research endeavors should explore beyond traditional teaching methods and investigate transformative pedagogies, reflective practices, and proactive measures that embed Diversity, Equity, and Inclusion (DEI) principles within nursing education programs. This focus on innovation and continuous improvement will better equip nursing students to handle the complexities of culturally diverse healthcare environments, thereby improving the delivery of inclusive and culturally sensitive care.

A collaborative effort is needed to adopt strategies and transformative pedagogies that ensure the effective integration of DEI into nursing programs, philosophies, curricula, and personal practice. This requires a thorough examination of existing practices, discourses, and educational philosophies that influence how cultural diversity is incorporated into nurse education. Nurse educators should proactively integrate DEI into curricula and explore new teaching methods to help students understand diverse patient backgrounds.

Moreover, nurse educators must embrace the personal responsibility of cultural humility by developing their knowledge and skills and reflecting on their potential biases. Lifelong self-development and research efforts should be paired with efforts to improve language inclusion, discuss cultural differences, explore cultural misunderstandings, address power differentials, and mitigate unconscious bias.

Continuous evaluation of nursing programs is crucial for ensuring that modifications are based on well-defined diversity efforts. This requires collaboration among nursing faculty, students, educators, and clinical staff to foster inclusivity, empathy, and respect, promoting a deeper understanding of cultural diversity and humility in healthcare practice. Such a coordinated approach will integrate cultural diversity into nursing education and practice, facilitating meaningful conversations about the role of cultural humility in addressing diversity and inclusion challenges in the future.

Chapter 4 Methodology

4.1 Introduction

In this chapter, I will discuss the selection of the methodology employed in my research study. Crotty (2003) discusses methodology as the conscious choices that underpin the design, methods, action plan, and processes that need to be aligned with the aims and objectives of the research study. Ataro (2019) states that the methodology in qualitative research extends beyond the choice of research methods and includes the ontological and epistemological assumptions that influence the researcher's knowledge, perspectives, and lived experiences of the real world in which they operate. Subsequent sections will present a rationale for my chosen research paradigm and approaches, offering a detailed account of the factors that influenced the paradigm choice, the criteria for sampling, data collection, and analysis methods, and ethical considerations. An explanation of the trustworthiness of this study will also be presented. Additionally, I will elaborate on my position as an insider researcher, in this qualitative study, detailing how it contributed to my reflexive journey throughout the research process.

4.2 Positionality

Savin-Baden & Major (2013) state that positionality refers to how the researcher relates to the research, the participants, and the process in terms of context and procedure. It was therefore necessary for me to determine my positionality from the outset of the research journey. Braun and Clarke (2013) suggest that researchers should identify their positionality in their research study and actively engage in the process of reflexivity. According to Holmes (2020, p. 2), positionality refers to the researcher's position in three areas: the research participants, the research design, and the topic under investigation. Therefore, locating my positionality involved identifying my values, beliefs, and biases, as well as my interest in the topic under investigation (Flick, 2006). Determining my positionality guided my decisions concerning the research paradigms and associated ontological, epistemological, and other assumptions that may interact with the research study (Holmes, 2020). In particular, I needed to remain aware of my individual experiences, values, and beliefs, especially in the context of cultural, political, and social factors that could unconsciously influence my research (Sikes, 2006). This awareness of my positionality allowed me to reflect on personal interpretations, experiences, values, and beliefs, and their potential influence on the research. This process ensured a reduced likelihood of imposing my personal opinions onto the data unnecessarily.

My position as an insider researcher also required me to reflect on my relationship with the environment and the chosen participants (Floyd & Linet, 2012). I was aware that my proximity to the study had the potential to influence my understanding of how others in the field construct their

identities and operate within specific contexts. This association prompted me to share experiences with colleagues to deepen my understanding and insights into cultural diversity and its practice in nurse education. Additionally, this required me to remain aware of the risk that my understanding and perceptions of the topic had the potential to influence the research process (Drake, 2010). I adopted the mindset that research is not a neutral process, and therefore I needed to explore my motives and consider the implications of my position in the research position (Sikes, 2006). By maintaining a reflective journal (Appendix A), I was consistently engaged with developing my awareness of my identity and examining my perspectives on the topic, the research process, and the study population (Savin-Baden & Major, 2013). The diary was instrumental in facilitating the documentation of my insights, perspectives, and characteristics throughout my research journey, facilitating my engagement with self-awareness and reflexivity.

The Covid-19 pandemic significantly influenced various aspects of my life and research, introducing considerable disruptions and necessitating substantial adjustments to my planned activities. The restrictions on physical movement and access to facilities meant that I could no longer conduct face-to-face interviews or visit physical archives, which were originally integral components of my methodology. This situation forced me to transition to remote research methods, including virtual interviews and the exclusion of a detailed investigation of documentation related to cultural diversity in nurse education. These necessary changes extended my research timeline and required me to develop new skills in remote data collection and analysis, which was an unexpected and challenging learning curve. Furthermore, the isolation from my student colleagues eliminated vital support and collaborative opportunities, which are essential for motivation and constructive feedback.

On a personal level, the pandemic introduced additional stress and health concerns for myself and my family, directly impacting my ability to maintain a consistent research schedule. Balancing personal well-being with academic responsibilities became increasingly challenging, leading to occasional gaps in my reflective practice. These gaps can be attributed to the heightened stress and the need to take breaks for personal stress management and to address ill-health issues. Missing the original submission deadline compounded these challenges, making it necessary to pause my research periodically. I also found myself needing to dedicate additional time to delve deeper into the theoretical foundations of my study. This was motivated by concerns regarding the adequacy and robustness of my theoretical framework. While this deep dive into the literature was essential for bolstering the rigor of my research, it also resulted in interruptions to my regular reflective journal entries.

4.3 Reflexivity

According to Olmos-Vega et al. (2023, p. 242), 'reflexivity is a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes'. In this respect, reflexivity is a practice designed to ensure that researchers maintain their subjectivity while considering the relationships between their 'context, identity, and research' (Olmos-Vega et al., 2023, p. 242). Reflexivity allows opportunities for the researcher to examine their worldview while interacting with others with respect to language, culture, history, and community (Cunliffe, 2016, p. 740). According to Alvesson & Sköldberg (2009), reflexivity is a crucial step in allowing the researcher to analyse their views of knowledge production and reality, guiding them in decisions related to paradigm selection. This process facilitates the examination of identity and positionality to ensure that the researcher provides an honest and trustworthy account (Probst, 2015) by confronting their assumptions (Wilson et al., 2022). Alvesson & Sköldberg (2000, p. 248) state that being reflexive is contingent on facilitating open and honest dialogue with participants throughout the research process. Marshall and Rossman (2011) state that fostering openness in research is essential to procuring rich data that will address complex issues. Therefore, it was very important in the research study to ensure that my role as a colleague and researcher remained respectful and inclusive. This shared identity fostered a sense of belonging and aided in building a reciprocal relationship (Davis et al., 2017) which was vital to the data collection process. Therefore, I encouraged participants to voice their opinions and perspectives, by providing a safe space and encouraging open dialogue, and endeavouring not to impose any preconceived assumptions about one viewpoint over another.

According to Berger (2015, p. 220), reflexivity 'means turning of the researcher lens back onto oneself to recognize and take responsibility for one's situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation'. This prompted me to keep a reflective journal (Appendix A) in which I could continuously question my relationship with the participants, the research topic, and all the data methods I chose to ensure objectivity throughout. I used the journal to document the evolution of my thoughts and insights, tracing my personal development and engagement with the research process. Additionally, I employed Microsoft comments in the coding process to keep a record of my reflections, comparisons, and similarities between my perceptions and those of the participants, as I transcribed and read the transcripts (Appendix B). I was more aware through this process of any assumptions I held and reactions to participants, and their experiences or opinions throughout the interview process. As an insider researcher, this process was of particular importance as failure to consider unexpected power dynamics in the interview process has the

potential to pressure participants to be hesitant to voice their full experiences (Olmos-Vega et al., 2023, p. 241).

4.4 The Research Paradigm

Denzin and Lincoln (2000) define the paradigm as a human concept that sketches the researcher's initial principles in the data. According to Kivunja & Kuyini (2017, p. 26), the paradigm has 'implications for every decision made in the research process,' guiding how researchers understand and address research problems, through a shared set of beliefs among scientists (Kivunja & Kuyini, 2017; Lincoln et al., 2011). Weaver and Olson (2006) state that the paradigm guides the process of research by determining a discipline's stance on requirements for knowledge development and production. They further explain that paradigms are crucial in characterising the ontological, epistemological, and methodological differences in the researcher's approach to their study.

Researchers opting for a positivist paradigm are focused on observables and measurables, which are often seen as deterministic and reductionist (Creswell, 2014). The positivist approach dominated research in the healthcare disciplines for decades, generating knowledge through deductive means to test empirical data constructs (Creswell, 2014; Creswell & Plano-Clark, 2011). Quantitative researchers align with positivist approaches as they value scientific methods in research studies. Therefore, positivist researchers, argue that truth can only be examined through empirical means (Henning et al., 2004, p. 17), producing scientific knowledge based on facts, while supporting an ontology that regards reality as independent of social construction (Walsham, 1995). This positivist philosophy embraces objectivity (Cresswell, 2014; Denzin & Lincoln, 2011) and involves hypothesis verification or theory testing in pursuit of a universal truth, where the researcher and participant maintain independence (Burns & Grove, 2011; Polit & Beck, 2012). The positivist approach is unsuitable for this study due to its reliance on controlled research methods and empirical testing (Denzin & Lincoln, 2008). In contrast, Creswell and Creswell (2018) state that knowledge that is developed through the post-positivism lens requires measuring and observing objective reality but also the behaviour of individuals is crucial to revealing social reality. Post-positivist researchers therefore, are concerned with the subjectivity of reality and do not rely on purely objective stances in the production of knowledge (Ryan, 2006).

According to Weaver and Olson (2006), the choice of paradigm in nursing has been influenced by positivist and post-positivist approaches to conducting research. I conducted a review of different paradigms in the post-positivist approaches to research as it aptly reflected the aim of my study. I chose the interpretivist approach but also recognised the influence of the constructivist paradigm. A paradigm comprises four dimensions; epistemology, ontology, methodology, and axiology

(Lincoln & Guba, 1985). Grix (2002) posits that the research decisions on all four dimensions are pivotal in establishing the flow of the research. Ontology, a branch of philosophy, explores the assumptions that shape individual beliefs about the nature of the phenomenon under investigation (Scotland, 2012). Ontology espouses the personal lens that researchers hold in the research studies which allows them to explore the possibility of multiple perspectives existing in the social world (Scotland, 2012). According to Cooksey and McDonald (2011), epistemology refers to the methods researchers use to establish what knowledge is and defines what qualifies as knowledge in the studied world. In the research process, epistemology underpins knowledge foundation and addresses questions about the nature of knowledge acquisition. According to Kivunja & Kuyini (2017, p. 28), axiology concerns the ethical considerations in a study, by determining the 'right and wrong behaviour relating to the research'.

According to Weaver and Olson (2006), the interpretive paradigm allows the researcher to obtain detailed data that can develop their understanding of the lived experiences of individuals in a particular field. The constructivist paradigm provides another lens that acknowledges that people socially construct their world based on their interactions, activities, and the context in which they take place (Maarleveld & Dangbegnon, 2002). In my study, I was focused on gaining rich data relating to the subjective experiences and interpretations of nurse educators in teaching cultural diversity, and on their openness to adopting new transformed pedagogies. However, I was also aware that their experiences, reflections, and interpretations have shaped their meaning of cultural diversity and influenced their educational practices. Therefore, I determined that the interpretivist/constructivist paradigm aligns with my worldviews and the principles ,beliefs, and values which are a key tenet of the study's aim. The interpretive/constructivist paradigm is an appropriate fit for my study, as it acknowledges that participant perspectives and understandings are constructed through shared social meanings obtained from a mix of consciousness, culture, and language. More importantly, this encompasses an understanding of participants' and researchers' experiences and knowledge in the research process (Mackenzie & Knipe, 2006; Mills et al., 2006).

4.5 The Interpretivist/Constructivist Paradigm

Qualitative methodologies are a form of social inquiry that aim to understand phenomena as perceived by a specific population, using interpretive approaches (Holloway & Wheeler, 2010). The interpretivist paradigm is situated in a contrasting epistemology to positivism as it allows the research to explore multiple realities (Dawadi et al., 2021), in which participant and researcher can develop an understanding of the 'world of experience' (Cohen & Manion, 1994, p. 36). According to Weaver and Olson (2006), the interpretive paradigm facilitates the development of knowledge,

understanding, and meaning that an individual construct from their interactions with others in a specific context. According to Robson (2011, p. 24), a central tenet of interpretivist research is developing an understanding of multiple perspectives of a phenomenon that is 'lived, felt, and undergone'. With interpretivism, the researcher's influence on the research investigation in terms of social, political, institutional, and cultural contexts is an integral aspect of the study. Interpretivism therefore has the epistemological stance that recognises the social aspect of research and other influences while recognising the researcher as inseparable from the research phenomenon. The use of this paradigm allows me to gain a rich understanding of the social construction of the participants' reality in practicing cultural diversity. These social constructions are articulated through the participants' narratives, voices, beliefs, and behaviours (Creswell, 2014). Interpretivism supports an ontological stance that reflects cultural influences and lived experiences, recognising the potential for multiple realities (Welford et al., 2011; Weaver & Olson, 2006).

Interpretivism and constructivism are two closely aligned but distinct paradigms in qualitative research that often work in combination with each other. Constructivism regards reality as subjective and changing (Bunnis & Kelly, 2010) in which 'entities exist only in the minds of the persons contemplating them' (Lincoln & Guba, 2013, p. 39). The constructivist paradigm is effective in addressing the 'unique experience of each of us' (Crotty 1998, p. 58). In this study, the constructivist lens enables me to understand the subjective meanings and interpretations of specific topics, by examining individual experiences from a cultural, political, social, and historical perspective (Creswell, 2014). Therefore, it involves a degree of intersubjectivity, wherein there is shared meaning and understanding between the researcher and the participants, acknowledging that knowledge is socially constructed and interpreted based on personal experiences and social environments (Mack, 2010). While developing an understanding of individual perspectives, constructivism avoids generalisations by considering the conditions and circumstances of people's lives (Ormston et al., 2014, p. 22), thus enabling the researcher to gain deeper insights into the phenomenon and its complexities within specific contexts (Creswell & Creswell, 2017; Weaver & Olson, 2006). Both paradigms will facilitate the development of knowledge by enhancing our understanding of how nurse educators construct their understanding of cultural humility and diversity. They will also explore how educators' perspectives and interpretations of cultural diversity inform their practice based on their lived experiences. Additionally, both paradigms possess an underlying ontology capable of providing asophisticated explanationa of the interactions within their respective domains, thus representing the distinct realities of the participants in the field of nurse education.

4.6 Participant Selection and Recruitment

Qualitative research using interpretive approaches often relies on purposefully selected small sample groups (Patton, 1990). This study utilised a purposive sample from one University in the Republic of Ireland as it facilitates the selection of information-rich cases for in-depth study Patton (1990, p. 169). This selection process allows the researcher to carefully choose knowledgeable participants who can contribute meaningful insights and data to facilitate an in-depth study (Parahoo, 2014; Patton, 1990). A purposive sample group facilitates the exploration of distinct and important multiple perspectives (Robinson, 2014) which aligns with the aims of the study. According to Creswell and Plano Clark (2011), purposive sampling involves identifying and selecting individuals who have the experience and knowledge specific to the phenomenon of interest. More importantly, individuals must demonstrate a willingness to participate and have the capacity to express, articulate, and reflect on the topic of interest (Palinkas et al., 2015, p. 2). Purposive sampling contributes to my study as it allowed me to choose a group of nurse educators with the appropriate qualifications and experience, who can offer valuable insights into their practice of cultural diversity, aligning with the aim of my study. According to Kelly (2010. p. 317), purposive sampling allows the researcher to 'select respondents that are most likely to yield appropriate and useful information.' Therefore, I chose a purposive sample of 10 participants, of varying age ranges, who met four criteria; having over 1 year of experience, knowledge about the topic, familiarity with the study context, and a willingness to express diverse viewpoints. All 10 participants, 7 females, and 3 males, are nurse educators with over a year's experience, meeting a key criterion for this study **(See Table 1).**

Table 1: Participant Demographics Overview

Pseudonym	Age Range	Years' Experience	Gender	Ethnicity
Linda	**30-50 years**	**> 1 year**	**Female**	**Caucasian**
Jodie	**30-50 years**	**> 1 year**	**Female**	**Caucasian**
May	**30-50 years**	**> 5 years**	**Female**	**Caucasian**
Bob	**50-65 years**	**> 10 years**	**Male**	**Caucasian**
Con	**50-65 years**	**> 10 years**	**Male**	**Caucasian**
Leo	**50-65 years**	**> 10 years**	**Male**	**Caucasian**
Ciara	**30-50 years**	**> 10 years**	**Female**	**Caucasian**
Kirsty	**50-65 years**	**> 10 years**	**Female**	**Caucasian**
Joy	**30-50 years**	**> 5 years**	**Female**	**Caucasian**
Emma	**30-50 years**	**> 10 years**	**Female**	**Caucasian**

4.7 Methods of Data Collection

Qualitative research studies aim to collect rich data to develop meaningful insights into the phenomena under investigation (Barrett & Twycross, 2018). Collecting qualitative data requires significant probing of participants' private views and perspectives on a specific subject through questioning (Price, 2002; Bourgeault et al., 2010). Using two methodologies can therefore support the examination of values, understandings, beliefs, and professional practice, regarding sensitive topics (Finch, 1987; Hughes, 1998). For this study, I utilised two approaches to data collection; vignettes followed by semi-structured interviews.

First, I sent the vignettes (Appendix C, D), the participant information sheet (Appendix E), and the interview guide (Appendix F) to the participants a week prior to the interview. This allowed time for reading, reflecting, and building familiarity with the scenarios and questions, to facilitate more meaningful responses. This time also encouraged them to seek clarification from me regarding any questions they may have about the process. Participants were informed that the interviews were online, via Zoom and would last between 45 and 60 minutes. The interview times were arranged in collaboration with the participants and were digitally audio-recorded through the medium of Zoom. My decision to use these methods was influenced by the adopted interpretivist/constructivist paradigm, which embodies a subjective epistemological position reflecting an understanding of the differences in social constructs dependent on individual beliefs, perceptions, experiences, cultures, ideologies, and norms (Baghramian & Carter, 2018). The choice of Zoom as a medium for conducting interviews aligns with the paradigm's emphasis on subjective understanding and the recognition of individual perspectives. Through Zoom, participants have the flexibility to express their viewpoints, experiences, and interpretations in a way that reflects their unique social contexts and backgrounds. I met with each individual for a semi-structured online interview, to explore their responses, reflections, and insights to the vignettes. The semi-structured interview also provided an opportunity to examine the individual's professional experiences with teaching and integrating cultural diversity into their practice.

4.7.1 The Vignettes

Vignettes were a chosen method to explore nurse educators, attitudes, values, understanding, and standard practices in education (Finch, 1987; Hughes, 1998). As a data collection method, vignettes enabled me to probe individual understandings, and experiences and to encourage discussion including individual values, beliefs, and experiences of the chosen topic (Skilling & Stylianides, 2020, p. 542). Vignettes can facilitate conversations on specific topics (Gray & Manning, 2013) through discussion that does not warrant direct questioning (Hughes & Huby, 2004). Participants can feel confident to safely articulate their beliefs, opinions, values, and

feelings about a particular phenomenon (Boddy 2005; Donoghue, 2000). The vignettes in this study were carefully designed to represent fictionalised characters to prompt the participants to reflect on the outcomes of the scenario (Jenkins et al., 2010). Therefore, the use of vignettes in this research had the potential to facilitate a better understanding of the experiences of the participants in a specific social context (Jenkins et al., 2010).

Torres (2009, p. 94) proposes that vignettes depict 'specific situations and the problems that might arise in them to probe informants about the way they understand these.' Therefore, the design of the vignettes needs to be realistic and believable (Stokes & Schmidt, 2012; Hughes & Huby, 2004). The scenarios need to depict flexible situations that enable individuals to consider their perspectives, beliefs, and interpretations in their responses (Poulou, 2001; Torres, 2009). Following Skilling and Stylianides (2020) advice, I drew inspiration from the literature and my own experiences in the chosen field, to construct both vignettes. From this, I developed short, concise, and static scenarios to reflect real-life situations (Hughes & Huby, 2004; Hughes, 1998) that were relevant to the environment in which the participants lived and worked. I was conscious when designing both vignettes that they were a close replication of educational practice, as if they appear too far-fetched they can stimulate unconvincing responses that do not reflect the respondent's reality (O'Dell, 2012) or multiple perspectives.

The design of the first vignette (Appendix C) concerned the inclusion of diversity content in key documentation in nurse education. In particular, I focused on the nursing regulatory body Nursing and Midwifery Board of Ireland (NMBI, 2016) documentation. The scenario was designed to enable participants to reflect on how culture and diversity are represented in the Requirements and Standards (NMBI, 2016) document, which guides the inclusion of diversity, equality, and inclusion (DEI) in nursing curricula nationally. In the scenario, a fictional character who is a nurse educator requested a departmental review of the inclusion of DEI in current nursing program documents, following attendance in a training program. I was guided by literature that proposes that the inclusion of cultural humility in nurse education requires careful planning (Foronda et al., 2022), and assessment of the curriculum to identify opportunities and areas that will support its integration into practice (Foronda et al., 2016). I utilised open-ended questions tailored to this vignette which are valuable in promoting rich discussions (Bradbury-Jones et al., 2014). It enabled participants to reflect on their current curriculum, guidance from their regulatory body, and the departmental philosophy about diversity and inclusion. The second vignette (Appendix D) presented a scenario reflecting a simulation practice in which nurse educators had to critically assess their approaches to diversity in scenario design. Following my observations in practice, I wrote a scenario in which nurse educators were challenged by students about the lack of

engagement with diversity in clinical simulation. This provided the participants the opportunity to reflect on current simulation practices, and scenario development, and to examine ways in which collaboration with students could enhance the inclusion of DEI in simulation to encourage critical thinking and reflection. For this vignette I also developed associated open-ended questions (Gill et al., 2008), using insights from the literature and personal experience to encourage further reflection and discussion.

I distributed the vignettes to each participant a week before the interview, to allow reflection on the sensitive nature of their content (Spalding & Phillips, 2007). Each participant was encouraged to contact me if they had any questions about the vignette. This included questions about the vignette design and possible interview questions related to it. Only one participant chose to do this and I was able to respond to their concerns with relative ease. While vignettes can stand alone as a method of inquiry, consensus suggests that their benefits are enhanced when used alongside other methods, such as interviews, to enable the collection of in-depth and meaningful data (Denzin & Lincoln, 2018; Hughes, 1998).

4.7.2 The Semi-Structured Interviews

A major strategy of data collection in qualitative research is interviewing, with semi-structured interviews being the most common data-gathering technique (Hennink et al., 2020; Holloway & Galvin, 2016). As a data collection method, the semi-structured interview allows participants to describe their experiences in their own words (Holloway & Galvin, 2016) and can facilitate the researcher to probe for additional information at a deeper level (Polit et al., 2001). It is an important tool in qualitative research to help the researcher gain a deeper understanding of the experiences and perspectives of participants (Cresswell, 2003) and to address information that is unpredictably raised in the course of the interview, enabling the detection and expansion of new data (Gill et al., 2008). The researcher's skill is pivotal to facilitating participants' recall and sharing of information and feelings, which significantly influence the data (Edwards & Holland, 2013). As my research explores nurse educators' understanding of the chosen phenomena, I felt the choice of the semi-structured interview was an appropriate methodological orientation, reflecting my ontological and epistemological assumptions. The interview is a particularly important method for this study, as they needed to be carefully planned, to ensure that responses to the vignettes and the follow-up interview captured meaningful data while guaranteeing that participants felt at ease when responding.

The interview is recognised as a form of social interaction in which one person guides the discussion through a series of carefully chosen questions (Seidman, 2013). Therefore, the interview guide for semi-structured interviews is designed to be flexible, directing the researcher

in the best ways to phrase questions and to move from broader issues to specific topics within the subject area (Doody & Noonan, 2013). Semi-structured interviewing allows the interviewer to modify the pace and style of questions in a manner that elicits rich responses from the interviewee (Qu & Dumay, 2011). In designing the interview guide, I included one broad opening question at the beginning and end of the interview. This allowed participants to expand on their experiences, perspectives, and approaches to the practice of cultural diversity and response to the vignettes. It is important to ensure that you are giving the participants the space to discuss meaningful topics and to engage with active probing (Doody & Noonan, 2013). According to Polit and Beck (2012), the art of knowing when to probe requires skill and understanding on the interviewer's behalf.

I asked each participant at the outset of the interview to describe their response to the scenario presented in the vignette. This broad and open question allowed scope and flexibility for the participants to reflect on the particular story presented to them in each vignette. At the end of the discussion related to the vignettes, I asked each respondent to add anything else they wished, based on their reflections. This allowed them the freedom to expand on their answers and to add any additional information that was meaningful to them. I continued to probe by asking questions like 'Can you tell more about your view/perspectives' or 'Can you expand on that point a little more' or 'You mentioned how teaching this area is challenging, 'Can you expand on that more?' Robson (2002). Probing is an interview skill that encouraged me to actively listen and recognise when to delve deeper into important discussion points (Smith et al., 2009). Roulston (2010) believes that forming positive relationships with participants is a crucial skill for researchers and essential to the success of the interview. Conducting online interviews can facilitate participation as it offers flexibility in terms of timing and location for participants challenged by adopting multiple roles in their lives (Davis, et al., 2017). However, Janghorban et al. (2014) state that there are benefits and drawbacks to online data collection that the researcher must be aware of. For example, researchers can be challenged to develop rapport with participants due to the lack of face-to-face interaction, affecting the interviewer's ability to develop trust and rapport with the respondent (Deakin & Wakefield, 2014; Janghorban et al., 2014; Seitz, 2016). I used simple measures, such as being aware of body language, reminding participants of their withdrawal rights, and referring to notes to avoid distraction, to ensure successful interviewing (Keen et al., 2022). I encouraged participants to choose a setting for the interview, and the participant information sheet helped establish online rapport, facilitating the collection of rich data (Keen et al., 2021; Roberts et al., 2021).

From an emic perspective, the insider researcher brings prior knowledge of the situation and culture under study (Gaber, 2017) which can help them develop a trusting relationship with the

interviewee. In my position as an insider researcher, there were also several considerations I needed to be aware of in the data collection phase. I was aware of the possibility that participants may be hesitant to share information that could potentially harm future working relationships. Thus, I endeavoured to adopt the qualities of a good interviewer, such as active listening, sensitivity, and vigilance to the information shared, to help build trust in the relationship. Throughout the interview, I adopted a reflexive approach to collecting data by endeavoring to build a good rapport with the participants while ensuring that I did not 'amalgamate their experience with mine'(Trainor & Bundon, 2019, p. 710). One limitation of using interviews as a method of data collection concerns the researcher's interpretations of the participant's message (Sjöström & Dahlgren, 2002). This challenging process often entailed a continual internal dialogue and critical self-evaluation of my positionality (Berger, 2015, p. 220). As an insider researcher, I continuously reflected on how my presence could influence conversation with them. I endeavoured to remain faithful to learning about their experiences and recognising the diversity among participants. Any misunderstandings or poor interpretations of the data can affect the quality of data collected. I had to remain vigilant of any tendency to filter their stories through the lens of my own beliefs, values, opinions, and experiences and refrain from imposing my interpretations on their data (Berger, 2015).

4.8 Data Analysis

The data was analysed following the process of reflexive thematic analysis (RTA) using a recognised framework that has evolved for some years (Braun & Clarke, 2006, 2013, 2019, 2020). RTA was chosen because it acknowledges the researcher's interpretive process as central to the coding stage. RTA is concerned with 'the researcher's reflective and thoughtful engagement with the data and the analytic process' (Braun & Clarke, 2019, p. 594). As an analytical tool, RTA highlights the researcher's 'subjective process' in knowledge production (Braun & Clarke, 2019; 39) through an iterative process of coding and theme development. It was particularly apt for me as an insider researcher who was familiar with the participants and the social context in which they worked.

Braun and Clarke (2020, p. 331) devised their framework to aid the process of reflective thematic analysis (RTA) as follows; 1) data familiarisation and writing familiarisation notes; 2) systematic data coding; 3) generating initial themes from coded and collated data; 4) developing and reviewing themes; 5) refining, defining and naming themes; and 6) writing the report. Braun and Clarke (2020; 332) highlight the need for the researcher to approach the analytical process, through 'immersion, wondering, writing, retreating, and returning to the data', a reflexive process that encourages continuous reflection on personal opinions, values, beliefs, and experiences. The

researcher is engaged in a critical thinking process that encourages them to ‘look for instances of similar or contrary language and experiences in the data’ (Braun & Clarke, 2020; 332). Reflective thematic analysis commenced as soon as I began transcribing the interviews, encouraging me to link broader themes across the data set, to gain a clearer picture of the investigated issues. This process of manual coding enabled me to gain meaningful insight into the participants’ experiences, perceptions, and understandings of the phenomena.

4.8.1 Data Coding Process

The process of familiarising myself with the data began with the personal task of transcribing the interviews. Drawing on Byrne’s advice (2022, p. 1398), I actively listened to the initial recordings to gain insight into the dataset, making note of pauses, gestures, and mannerisms that enriched interpretations of the spoken word. As I transcribed, I documented additional reflective notes using the comment function in Microsoft Word (Appendix B). Braun and Clarke (2022, p. 72) state that ‘coding is an organic and evolving process, capturing an interweaving of the knowledge, subjectivity and analytic skill of the researcher, while engaging closely and systematically with the dataset. The latent coding process, in this study, enabled me to explore explicit meanings closely aligned with the participant’s language, allowing for deeper, implicit, or conceptual meanings to be drawn (Braun & Clarke, 2019). My coding process was drawn from my continuous engagement with the data, concentrating on the participants’ attributed meanings which related to their reflections on current practice and understanding of cultural diversity. I systematically worked through the data, meticulously identifying and interpreting significant passages that conveyed the participants experiences. I read each transcript and assigned broad codes to particular passages, manually colour-coding sections as I read through the transcripts (Appendix G). I considered this process as the "messy phase" of coding as it involved a lot of hands-on work and some complexity and disorderliness in managing the data.

Braun and Clarke (2022) recommend at least two rounds of coding. After printing new transcripts, I began a second round of coding while taking note of the initial colour-coded sections. I refined and developed specific codes for each interview incorporating comments throughout to record and highlight my reflexive journey. This was done to contextualise my understanding and ensure that I captured the participants’ narratives authentically (Appendix B). I identified and compared different and similar experiences and perspectives to allow for meaningful interpretations of the data. I went back to the data again to refine the codes by attending to each data item with equal consideration. This involved the next step of analysis, reviewing the data from different perspectives and re-engaging with the narratives, to ensure that all codes were relevant, informative, and reflective of the participant’s voice. This open organic coding process sought to

capture all aspects of the data, relevant to participants' understanding of cultural diversity. This process generated 6 codes in vignette 1, 9 codes in vignette 2, and 16 codes in the interview data set. With all data systematically coded, I categorised similar codes into single codes or sub-categories, a prerequisite for developing themes (Braun & Clarke, 2013, Appendix H).

4.9 Theme Development

In the subsequent phase of analysis, I began to develop themes by categorising broader 'patterns of meaning, underpinned by a central organizing concept – a shared core idea' (Clarke & Braun, 2017; 297). The development of themes necessitates that they communicate something vital about the data concerning the research question (Braun & Clarke, 2013, p. 82). I sorted my codes according to 'clusters of meaning' (Braun & Clarke, 2019, p. 855) and organised them so that I could identify overarching themes and sub-categories (Braun et al., 2016). For each transcript, I created a Word document and transferred the narratives from the codes that aligned with the emerging themes (Appendix H). This process should be approached with the understanding that themes do not simply emerge from the data, but result from an active phase of analysis during which they are developed (Braun & Clarke, 2019). This process kept me continuously engaged with the data, aiding the identification of themes across all three data sets. Braun and Clarke (2013, p. 65) caution that themes should be 'distinctive and, to some extent, stand-alone' but are also required 'to work together as a whole.' Maintaining consistent engagement with the data ensured that I could prevent issues like theme overlap and lack of coherence, which might lead to superficial analysis of the data (Braun & Clarke, 2006). In the final stage of the analytical process, I examined all the emergent themes. The objective was to identify connections across all data sets and pinpoint prominent and frequently recurring themes, enabling me to group similar themes. From this process, I generated three overarching themes from my perceptions of the broad patterns of meaning that emerged across the codes (**See TABLE 2**).

TABLE 2: Themes and Sub-Themes

Themes	Sub-Themes
Personal and Professional Responsibility	**Nurse Educators' Responsibilities to the Student** **Personal Attributes and Skills** **Recognising and Reducing Implicit Bias**
Current Approaches to Teaching Cultural Diversity in Practice	**Adopting the Individualised Model for Teaching Cultural Diversity** **Teaching Strategies for Cultural Diversity** **Concerns Related to Teaching Practice**
Cultural Humility ~ A Pathway Forward for Nurse Education Practice?	**Current Understandings of Cultural Humility** **The Role of Reflection** **Team and Organisational Support** **Educational Requirements for Nurse Educators**

4.10 Ethical Considerations

Researching life experiences and possible inspection of personal belief systems can be complex, as recounts are contextually value-laden. The ethics involved in using an interpretive /constructivist methodology in research requires the researcher to be aware of disclosing sensitive data, which involves a reflection of personal attitudes and approaches to cultural differences and practices. Therefore, I needed to be engaged with the appropriate steps to uphold participants' dignity, confidentiality, rights, privacy, and anonymity (Creswell, 2003). Ensuring informed consent, safeguarding the rights of participants, and maintaining confidentiality, is an essential element of ethical research. Ethical considerations that are relevant to this study include ethics committee approval; sensitivity to disclosure of data; informed consent; data management and storage, and ensuring participant confidentiality.

4.10.1 Ethical Approval Process

Obtaining ethical approval before commencing research on any chosen topic is essential. To ensure adherence to fundamental ethical principles outlined by each University, I required ethical approval from the Technological University of the Shannon (TUS) and the College of Social Sciences Ethic Committee at Glasgow University (Appendix J). This meticulous process also served to uphold participant safeguarding in line with recommended research practices. To access

participants working in the Nursing Department at the Technological University of the Shannon (TUS), I communicated with the Head of Department. This step was taken to inform him about my study and to ensure that no obstacles would arise in involving employees from the Department. Following the guidelines provided by both Universities, I meticulously completed the required application forms, ultimately achieving successful ethical approval from both institutions.

4.10.2 Consent, Confidentiality and Withdrawal

I provided each participant with an information sheet to ensure informed consent. The information sheet outlined the study, ensuring participants' full awareness of the implications of their involvement. Prior to the interviews, I had face-to-face discussions with each participant to address any queries they had about participation or the consent process. Additionally, at the beginning of each interview, I allocated time to review the consent form (Appendix I) before obtaining their consent to participate in the study.

Another crucial aspect of the research was to ensure the safety and well-being of the participants in the interview (Gray, 2004). As the study explored participants' perceptions about culture, bias, and practices regarding cultural diversity, I emphasised the importance of recognising and addressing any harm or discomfort they may experience from participation in the study. Participants were assured that if they felt distressed during the interview, they had the option to pause or terminate it at any point if they were distressed. To further support their well-being, I informed them of available counselling services within the Technological University of the Shannon (TUS). With respect to participants autonomy, I emphasised the right to withdraw from the study at any stage. This right was discussed both verbally and in writing, as indicated in the participant information sheet. Although this option was presented, none of the participants felt the need to exercise this right.

Participant anonymity is a fundamental tenet of ethical practice in qualitative research (Parry & Mauthner, 2004). All potential participants received the consent form, allowing time to examine it before obtaining recorded formal consent. Furthermore, to further protect their identities participant names and any identifying details were removed from all research documents ensuring anonymity throughout the research process. To preserve confidentiality, participants were assigned pseudonyms, ensuring only the researcher knew their real identities. Moreover, to maintain the highest level of confidentiality and accurate representation, I conducted and transcribed the interviews. As the primary transcriber, I remained cognisant of my ethical responsibility in translating their spoken words into text (Marshall & Rossman, 2011, p. 167). I validated accuracy by returning transcripts to two participants for confirmation. I ensured that I maintained sole access to the collected data during the study. I will also ensure that collected data

will be securely stored for a maximum of 5 years, following ethical guidelines set by the College of Social Sciences Ethic Committee at Glasgow University.

4.11 Trustworthiness

Lincoln and Guba (1985) are acknowledged as the pioneers of essential criteria for quality in qualitative studies. Their original framework has been modified over time by Denzin and Lincoln (1994) to encompass the concepts of credibility, transferability, dependability, and confirmability, as accepted criteria for rigour in qualitative research (Murphy et al., 1998). To ensure trustworthiness in this qualitative study, I employed the above criteria.

Credibility is defined as the extent to which the participants endorse the researcher's conclusions (Murphy et al., 1998). Participant validation or member checking through the feedback process is the primary technique for assessing the credibility of data and interpretation (Sandelowski, 1993; Guba & Lincoln, 1994). Credibility is established by sharing the data and interpretations with a small number of participants (Koch, 2006).

Participants were sent their transcripts to ensure the accuracy and reliability of the interview. This ensured that the data genuinely reflected their interpretations and experiences and assessed the extent to which the results could apply to current or other contexts. Important aspects were also shared with supervisors in follow-up meetings throughout data collection, analysis, and report writing. This approach prevented me from aligning too closely with participant views while losing sight of other perspectives. According to Denzin and Lincoln (1994), this form of debriefing is known to enhance the credibility of analysis and clarify any complexities that arise during data interpretation. Practically, this involved considering how my assumptions as a researcher could influence data collection and analysis, as well as any processes that could shape the findings. This process facilitated a reflexive approach and contributed to the rigour of the study.

I aspired to make the research process and the richness of the data transparent when reporting the findings, ensuring that the transferability of the results can be applied to other settings or groups (Polit & Beck, 2012). The various stages of the data collection, analysis, reporting and my role in influencing the data are highlighted and discussed in terms of their potential impact. Many of the aforementioned steps also contribute to establishing confirmability by ensuring that the data accurately reflects participants' information and that the findings are grounded in reality (Polit & Beck, 2012). By documenting my reflections and being aware of any bias or assumptions I might bring to the data set and research context, confirmability can be established (Guba & Lincoln, 1982; Lincoln & Guba, 1985).

Dependability pertains to the stability of data over time and under different conditions, referring to multiple inquirers independently arriving at the same or similar interpretations. It is achieved by ensuring that I remained faithful to the meanings derived from the data at the time they were obtained. Lincoln and Guba (1985) also suggest that when credibility is established, dependability is assumed. Both elements can be attained through robust documentation of the research project, including participant selection, data collection methods, findings, and interpretations of the data (Lincoln & Guba, 1985; Thomas & Magilvy, 2011). The persistent pursuit of rigour in qualitative research has always raised challenging issues for the researcher, but Sandelowski (1993, p. 2) states that it is achievable if the researcher ensures 'fidelity to the spirit of qualitative work.'

4.12 Summary

In summary, the chosen research design in this qualitative effectively aligns the research methodology with the research questions and aim. The chosen interpretivist/constructivist paradigm allowed me to explore and understand the individual experiences of the participants, through their own personal interpretations and the diverse meanings they apply in specific contexts. Using a purposive sample of ten educators working at one university in Ireland, rich data were collected through the medium of two vignettes and individual semi-structured interviews. Data was subsequently analysed using a reflective thematic analysis framework (Braun & Clarke, 2019) which allowed me to identify themes and sub-themes to enrich the study findings. Additionally, ethical considerations and trustworthiness were also addressed in the research process ensuring that the study remains robust and maintains the quality and validity of the findings. Positionality and reflexivity are also important elements of the study, ensuring that I was actively engaged in the research process, especially as an insider researcher. These approaches helped to ensure that this study is an accurate, empirically rigorous, and balanced report of the participant narratives. These narratives will be presented and explored in the following chapter.

Chapter 5 Presentation of the Findings

5.1 Introduction

This chapter presents the findings from this study. Consistent with the interpretive/constructivist methodology, extracts from the data will be presented to support my interpretations. I have used pseudonyms for each of the ten participants; Linda, Jodie, May, Bob, Con, Leo, Ciara, Kirsty, Joy, and Emma to ensure that confidentiality is maintained. I have endeavoured to ensure that each participant has been given a voice to reflect on their individual choices, experiences, and perspectives. The following sections present the themes and sub-themes.

5.2 Themes

Three main analytical themes were identified as follows:

Theme 1: Personal and Professional Accountability

Theme 2: Current Approaches to Teaching Cultural Diversity in Nurse Education

Theme 3: Cultural Humility ~ A Pathway Forward in Nurse Education Practice.

Each theme consists of several categories that represent participants' perspectives of their worlds and explore the complexities of teaching cultural diversity and the possibility of embracing new approaches in the future. These themes are further articulated into sub-themes, as follows:

Theme 1: Personal and Professional Responsibility

- Nurse Educators' Responsibility to the Student
- Personal Attributes and Skills
- Recognising and Reducing Bias in Practice

Theme 2: Approaches to Teaching Cultural Diversity in Practice

- Adopting the Individualised Model to Teaching Cultural Diversity
- Teaching Strategies for Cultural Diversity
- Concerns Related to Teaching Practice

Theme 3: Cultural Humility ~ A Pathway Forward for Nurse Education Practice?

- Current understandings of Cultural Humility
- The Role of Reflection

- Team and Organisational Support
- Educational Requirements for Nurse Educators

The themes and sub-themes are discussed in this chapter, to give an overview of the research's main findings.

5.3 Personal and Professional Responsibility

Participants expressed a sense of responsibility for incorporating cultural diversity to some extent in their practice. This sense of responsibility emerges from observing the evolving changes in society in which students and educators now practice. Linda states:

> Society is always changing and patients are going to always have different needs and come from different backgrounds … therefore we need students to be qualified, to be able to go out and continue their journey of being aware and culturally competent.

While Jodie concurs with this point, she also reiterates the importance of nurse educators being informed of the changing diversity in society. She states:

> Our patient is changing and our society too and sometimes it is about keeping abreast of those changes and giving ourselves time to adjust by being open and aware.

This sense of responsibility became more evident as educators participated in this study. Many of them articulated that reading and reflecting on the vignettes prompted them to assess their approach to cultural diversity, both personally and professionally. Bob stated that the vignettes made him ponder, 'Do I actually consider culture and cultural issues in class?' Jodie echoed this sentiment,

> And I think again like vignettes are very thought-provoking …then you know does make you stop, reflect and focus in on what do I do as a lecturer.

While the narratives demonstrate a clear sense of personal responsibility, it's noteworthy that educators relied on a medium, such as participating in this study, to stimulate reflection on their approach to cultural diversity in practice. Therefore, it is important to extrapolate the impact of these reflective activites on cultural diversity practice to ensure future nurses are prepared to meet the changing diversity of patients in complex healthcare systems.

5.3.1 Nurse Educators' Responsibility to Students

A key responsibility identified by the participants of this study is ensuring that the student is sufficiently prepared to deliver culturally sensitive care to diverse patients. Participants appear to indicate that this role is multifaceted in terms of their duties and professional responsibilities. Kirsty believes that students need to be proficient, if they are 'to engage properly with society and have the skills to deliver care across all cultures.' Jodie states that students need to be prepared to 'provide a quality service, which can only be achieved if they are competent to engage with people from different cultural backgrounds and develop cultural sensitivity.' Linda reinforces this by stating:

> We have a professional duty and a professional responsibility to make sure that we are now sending out culturally competent and culturally aware students… we need to be thinking about the nurse that's going out at the end and all the different components and different cohorts of people they will be meeting.

Linda's perspective highlights the need for students to understand the unique cultural attributes of diverse societies to promote inclusivity in cultural care. Therefore, participants demonstrate an awareness of the significance of their role in broadening perspectives on patient differences to ensure students are practising inclusively. Emma also emphasises the significant role educators play in the students' development of cultural diversity. She says:

> So, you are accountable that these students can go out and are capable of dealing with a diverse range of people and are able to meet the client's needs.

As part of this remit, Linda suggests that educators are responsible for cultivating autonomous practitioners:

> We need to create these reflective practitioners in nursing ….to make critical thinkers of all our nurses, and let them think for themselves, and be practitioners in their own right.

Linda's narrative implies that educators need to move beyond rote learning in order to cultivate a good practice of culturally sensitive care. They need to ensure that students are engaged with critical thinking, acquire problem-solving abilities, and be autonomous in making the appropriate clinical decisions about diverse patients. In facilitating this learning of critical thinking, nurse educators can equip students with the skills to navigate complex healthcare systems, make clinically sound decisions, and respond to the evolving needs of patients. This suggestion adds another dimension to the role of the educator and gives an indication of the enormity of their responsibility in nurturing skills necessary to provide culturally sensitive care.

Ciara feels that in their instruction educators should broaden their content to include issues of gender, socioeconomic status, cultural norms, and cultural background as integral to understanding patients' diverse needs. She states:

> We need to understand where the patient is coming from, their socioeconomic status, gender issues, values, and norms, as different cultural groups perceive illness, disease, and health differently.

Ciara and Kirsty emphasise a need for nurse educators to ensure that students are developing an understanding of patient care based on individual health beliefs, values, and preferences when addressing diverse needs. These narratives suggest that cultural diversity content in nursing programs is currently limited, requiring strategies that are focused on predicting health behaviours that affect patients' experiences and responses to healthcare initiatives. This indicates a requirement to review current curricula to ensure more engagement with inclusive practices that are responsive to changing healthcare environments and service users.

Kirsty believes a sense of responsibility to students includes the need for educators to act as role models, particularly in demonstrating the values that are important to cultural sensitivity. She notes that:

> The value system that we actually demonstrate by our example accommodates the various nursing student and patient diversity that's going to be there and that we really know is essential to our teaching.

Bob, Linda, Kirsty, and Ciara stress that classroom discussions and teaching strategies should be designed to nurture values of empathy, respect, kindness, and non-judgemental attitudes in providing culturally sensitive care. Kirsty states:

> To teach them never to judge a person until you have walked a mile in their shoes, ….you know, trying to put yourself in somebody else's shoes.

Linda believes that approaches to teaching cultural diversity need to focus more on cultivating an understanding of cultural differences as well as embedding values of respect and collaboration. She states:

> I think promoting empowerment, respect, and partnerships will help create open multiple perspectives, which I think is really important as well for the nurse-patient relationship to improve that aspect also.

When discussing 'multiple perspectives,' the suggestion is that creating learning environments is essential to ensure that cultural differences and perspectives converge and act to inform new interpretations of patient differences and associated needs. Kirsty reiterates this point stating:

> We need to teach them about patient differences in a way where they are showing respect and empathy in their choices and to recognise their patients' needs are different and individual.

The implication is that a more value-based teaching approach can encourage students to consider holistic factors in caring for diverse patients beyond focusing on symptom management. It cultivates a view of the patient that respects the contribution of personal values, beliefs, traditions, and differences to healthcare journeys. This perspective can enable students to become more aware of their value systems and recognise the need to foster attributes that are conducive to delivering culturally sensitive care.

Jodie, Linda, and Emma emphasise the importance of developing skills of self-awareness as essential to enhancing student learning. Jodie comments, 'to prepare students to have that level of self-awareness and that level of desire and to want to know more and to take on board the skills to be able to care for diverse populations.' This suggests that nurse educators believe that self-awareness is an essential value and skill for students to develop when working in dynamic and diverse healthcare environments. However, they also note that fostering self-awareness in students is challenging, and depends on nurse educators' skills in harnessing this value. Emma states:

> I think before you have to teach or before you can help somebody you have to know yourself before you can teach them to do likewise which is difficult.

This perspective, articulated by Emma suggests that educators also need to develop self-awareness and an understanding of themselves before they can foster culturally sensitive behaviours and approaches in others. Although many of the nurse educators spoke about reflection and discussion as being essential to their approaches to fostering self-awareness in their student group, there also appeared to be a lack of structure in terms of developing strategies to nurture this skill. With no structured method to evaluate whether students were leaving the nursing program with the ability to be self-aware, there is a possibility that students are not currently developing this skill in the classroom setting.

This study emphasises the sense of responsibility nurse educators feel in their role of harnessing cultural diversity skills in their students. Their role is significant in that it includes fostering attributes and skills in students necessary to provide optimal care to diverse patients. Nurse educators also support a change to curriculum content, to support the development of essential values necessary to work with diverse populations. The emphasis on developing self-awareness to promote inclusivity is also interesting but educators' approaches currently lack direction in this

respect. These findings have significant implications to prompt a review of current practice concerning the curriculum and educator's role in promoting culturally sensitive care.

5.3.2 Personal Attributes and Skills

Nurse educators emphasised that their proficiency, knowledge, and skill in teaching cultural diversity are crucial to student preparation and engagement with cultural diversity. Kirsty states:

> I suppose the way I look at it is that if you are a competent lecturer, you should be able to deliver on cultural diversity and to make sure students are learning also.

The narrative suggests that there needs to be a focus on the personal skill set educators require to teach cultural diversity effectively. Both Linda and Kirsty advocate that educators should continuously maintain cultural awareness to meet the needs of students. As Kirsty states:

> We have to be aware of our whole perceptions, our attitudes, our knowledge, and our interactions and that we have to be at all times very sensitive to others and their needs; it's a continuation to think of acquiring the skills and the practices so that, we move on and become better educators to create better learning environments.

This is significant to educational practice indicating that commitment to personal development should be ongoing to ensure that students are learning about cultural diversity. This obligation extends beyond the acquisition of knowledge and incorporates the need to adopt more awareness of the personal attributes required to prepare students for culturally sensitive care. Participants are indicating here that they are not just responsible for student learning in the classroom but also for how they influence their approaches to cultural diversity throughout their nursing careers. To ensure that nursing students are equipped with the appropriate skills and attributes educators need to be exemplifying these values also. Therefore, educators need to ensure that they commit to professional and personal development if they are to succeed in their role of preparing students to deliver culturally sensitive care to diverse patients.

Some participants who had recent experience in clinical practice found that interacting with diverse patients helped them to develop a deeper comprehension of cultural differences. Both Con and Linda identified significant differences in the development of knowledge of cultural diversity between clinical and educational settings. This is significant as it recognises that cultural interactions and clinical exposure can create a more enriching learning experience for educators as well as students. For example, Linda feels that working with the travelling community was significant in developing her cultural awareness. She comments:

> I also feel that when I was working with the travelling community as a nurse, I had a much more heightened awareness of everybody and what everybody needed in that ethnic minority. But when I stepped away from clinical practice and came to education, you just kind of fall back into your old ways again.

The implication is that engaging with more culturally diverse encounters can enhance knowledge of different cultural backgrounds, beliefs, and experiences, thereby fostering an understanding of diversity beyond educational settings. There is a suggestion that educators need to seek opportunities to engage with more diverse individuals and environments to develop an awareness and an understanding of the complexities involved in caring for diverse patients. This knowledge can be utilised to develop new teaching strategies to ensure that nursing graduates are well-prepared to provide culturally sensitive and effective care.

For Kirsty, Ciara, Con, Bob, Leo, and Jodie the importance of educators being inclusive, respectful, compassionate, non-judgmental, non-discriminatory is essential in their practice. Additionally, practicing self-acceptance and self-examination are seen as crucial aspects of their professional practice. Where knowledge was deemed significant, these narratives suggest that faculty members' adherence to professional values and ethics, is equally important in developing an awareness of cultural diversity. This implies that consideration of ethical values can promote empathy, open-mindedness, and the ability to acknowledge and respect different cultural perspectives. As Linda states:

> To make sure that I am open to other people's perspectives other people's, beliefs, other people's, values, and respectful to them in order to broaden our views and our opinion of culture.

Interestingly, the most prevalent attribute articulated by all participants was the need for educators to develop self-awareness in themselves. The overall suggestion is that this personal analysis helps them understand their strengths, values, and limitations, and recognise their students' needs in terms of addressing cultural diversity. Linda states:

> I need to have a level of self-awareness… that I'm aware of my own biases, my own knowledge, what I don't know as much as what I think I do know. That I am open and respectful to other people's perspectives, beliefs, values.

This implies that self-awareness plays a crucial role for educators in comprehending cultural disparities and identity, which are vital for instructing on the care of diverse patients. Being self-aware can ensure that educators are open to diverse perspectives, which is crucial to ensuring that students adopt inclusive attributes in their practice.

Con also suggests that self-awareness is important in ensuring that a monocultural perspective is not prevalent in his teaching approaches. He comments:

> You need to be self-aware, particularly if your own ethnic grouping for example is white Irish… because sometimes it's just easy to assume that we all think and have the same values.

Linda and Con's narratives highlight the importance of educators embracing different perspectives in their teaching approaches, thus encouraging students to adopt similar principles in their practice.

Con suggests that self-awareness is also pivotal in encouraging educators to assess the effectiveness of curriculum documents and NMBI's requirements and standards in guiding the teaching practice of cultural diversity. Vignette one was designed to encourage participants to reflect on some of the core documents available to guide their practice of cultural diversity. However, it became evident that the participants were not as engaged in this form of reflection on their practice, compared to the scenario presented in vignette two. This is an interesting observation, as nurse educators did not seem to consider how power relationships and authoritative voices could influence their teaching. This lack of critical engagement may reflect the historical context of nursing as a profession. This can have a detrimental effect on student learning and departmental engagement with efforts to create more inclusive environments.

Self-awareness was also considered crucial in understanding how individual differences in personal value systems can impact the interactions between nurse educators and their students. According to Bob, interpretations of these differences can cause cultural conflict in classrooms, further isolating minority students and hindering their knowledge development. Con concurs with this stating:

> You have to be aware of where you came from yourself and what generates your value system in order to be able to recognize the value systems of others…. okay so she wants an abortion I might not agree with abortion or okay, she wants to he wants to commit suicide even though I think that's a really bad idea from my own value systems …but when I go away from it, I think what did I say to that person about my value systems or did I impose my value systems on that person.

This is an important finding as it indicates that personal value systems can create conflict when different opinions and perspectives are expressed. Cultural clashes can occur when individuals hold contrasting beliefs about family, customs, society, health, and well-being. This is an essential part of developing self-awareness for educators, to ensure that they are modelling behaviours that exemplify acceptance and tolerance of other people's views and beliefs. This prepares students to emulate these behaviours and attitudes when caring for diverse patients in the clinical area.

A key finding of the study indicates that nurse educators play a significant role in exemplifying the values, skills, and knowledge that are required to ensure that culturally sensitive care is being provided to diverse patients. Overall, these narratives have explored the personal value systems that educators feel are required to prepare students to deliver culturally responsive and sensitive care. While acquiring knowledge and competence is important, the narratives also highlight inherent attributes of cultural diversity practice. The need for educators to develop self-awareness as part of exemplifying these attributes, is a key finding of the study. The narratives effectively highlight how self-awareness is pivotal to personal and professional development as it prompts educators to explore their perspectives, biases, values, and their potential to influence their teaching practice. Self-awareness is a valuable attribute to engage educators in recognising the needs of their students when addressing cultural diversity.

5.3.3 Recognising and Reducing Bias in Practice

In the narratives, there is a suggestion that the current practice of cultural diversity can be strengthened by increasing nurse educators' engagement with recognising and reducing personal bias. There appears to be a unanimous opinion that unconscious bias reflects a personal ethos and attitude that can influence educators' teaching practices and student learning. These ingrained ideas can affect the educator's interactions, behaviours, and capacity to make decisions that ensure inclusivity in their teaching practice. Participants also emphasised the importance of examining bias, particularly its impact on the self. Linda states:

> It's about the awareness of having biases and for me to be able to stand and self-reflect and say, that's my bias but how can I remove that, or how can I minimize that to be able to facilitate teaching.

By examining personal bias, participants feel that it enables them to assess how their own beliefs, experiences, and identity can affect their interactions with students and their teaching approaches. It is important to note that participants did not explicitly express if they currently adopted strategies to examine personal bias or its potential influence on their teaching. However, evidence from the data suggests that through their practice of reflection, they often encounter incidences that prompt them to consider their bias and address it. Kirsty provides an example of facing a personal bias within herself while navigating the change to gender-neutral toilets in her workplace:

> I am using the changing gender in the toilets as an example. Initially, I was kind of thinking, 'How can I accept it?' I suppose the reflection comes from understanding that once there is equality and understanding, that's really the most important thing. Our understanding stems from knowledge, and that knowledge gives us the confidence to learn how to accept.

This example indicates that educators are engaging with self-reflection to identify and address personal biases even if not deliberately structured. New understandings gained from this practice have several benefits, including the reduction of bias and the avoidance of viewing culture in a one-dimensional manner. Developing new perceptions of cultural diversity can help educators to challenge entrenched beliefs thereby avoiding discriminatory behaviours that can affect cultural encounters. This example demonstrates how Kirsty challenged her bias to explore different perspectives, through reflection, which she can use to enhance her teaching practice. Therefore, reflection of bias is a valuable tool for both educators and students in diverse encounters and can result in personal growth and enhanced practice of cultural diversity.

Recognising and reducing bias can also enable educators to create respectful and inclusive approaches to their teaching. It allows for the development of a new understanding of cultural differences that promotes respectful responses to providing culturally sensitive care. Linda states:

> By recognising and addressing bias, the educator can improve their practice and improve student learning which would ultimately benefit the service user and patient outcomes.

The implication is that the examination of bias should be an integral component of individual practice and a central focus of the faculty's philosophy as a professional body. Jodie comments:

> We also have to be aware that when we don that professional uniform … we have to leave limitations, biases, and prejudices at the door, and act in a professional manner.

Linda, Leo, and Ciara stressed the importance of educators cultivating efforts that would prompt students to challenge their personal biases as well. Both Leo and Linda recognised a bias within nursing student groups that often remained unchallenged due to a lack of awareness. This particular bias is towards the traveller community and is prevalent not just in the student group but can also be embedded in the clinical area. Linda had extensive experience working with this indigenous community and noted the prevalence and scope of this bias. She explains:

> Students have their own biases too. They have great empathy for every other culture except for travellers. Where is there any kind of, you know, cultural awareness in that situation? It is a prime example of people putting prejudices, preconceived ideas, and biases onto a small group of people and continuing to view them as not having cultural needs different from other Irish people.

Here, Linda is articulating a collective ambivalence toward this particular diverse group of individuals. Using this indigenous group as an example is interesting because it exemplifies how educators, students, and nurses can remain unaware of the existence of bias in healthcare and

society in general. This often has a detrimental effect on this group, perpetuating healthcare inequalities and disparities, which promotes poorer healthcare outcomes for them.

Ciara and Kirsty reflected on the need for a collective approach to address bias in nurse education. In the following narrative, Ciara indicates that cultural humility has the potential to improve this element of their practice. She states:

> In terms of cultural humility, you can have prejudices and ignorance in departments and healthcare as well as in an individual and we probably don't realize that we need to be doing it…but the effect on patients is concerning.

Although nurse educators recognise that students can harbour biases, they do not have a formalised approach to help them recognise and address them. Participants feel that self-awareness is key to addressing these challenges but are less confident about ways to facilitate this learning in their students. This indicates that nursing faculties and educators need to explore strategies that will promote the examination of bias and its implications on patient care.

There are other examples of perpetuating bias in healthcare systems that can influence how professional groups address the delivery of diverse patient care. Bob refers to how gender stereotypes are a cultural norm in healthcare systems, which can inadvertently foster unconscious biases. He uses the example of how gender differences are often prevalent in nursing, where attitudes toward male nurses are often different from females. He states:

> And then that spreads into all the other areas of ethnicity assumptions that people make about nursing practice and how nurses react to different ethnic groups and it comes out in issues like caring for the dying, you know, we have loads of issues around sensitivity with those issues.

Bob's example illustrates the prevailing gender differences in attitudes toward male and female nurses. Therefore, bias can be noted in the different expectations both genders face, reflecting a particular set of gender stereotyping in healthcare. The challenge of facing bias becomes more difficult when nurses are treated and evaluated differently in their professional field. There is a need to recognise gender stereotyping rooted in healthcare to promote equitable and inclusive workplaces for healthcare professionals, regardless of their gender. This recognition is important in shaping approaches and attitudes that exemplify openness and respect, which can be modelled in patient care. There is a need to consider interprofessional educational initiatives to address bias to ensure that the future workforce is developing culturally responsive and sensitive approaches to care.

In Bob's example, gender biases in healthcare explain why both male and female nurses face bias in the healthcare profession. Similarly, Linda's example illustrates how indigenous groups experience different healthcare outcomes due to inherent bias in the profession. By modelling such bias to students, educators, and nurses are at risk of imposing their values and beliefs in their instruction, which can negatively affect the practice of cultural diversity.

There is also an indication that cultural humility could be beneficial as a guide to examine bias allowing opportunities to address them in the learning environment. It is important to develop this approach to allow sensitive and inclusive care practices to develop in the educational arena. Ciara reiterates this point:

> We have to park all those biases and train our students to park their biases and preconceived ideas there is huge learning in that approach to improve patient care.

This perspective indicates that cultural humility offers opportunities to ensure that educators are teaching essential values necessary to practice culturally sensitive care. Reflection on personal bias in teaching practice can also ensure that bias and stereotypes are not being reinforced in the classroom or the clinical area. Joy states:

> We need cultural humility to look at do we have any biases and even just to note how much do we know about a particular sex, sexual orientation, religion, ethnic background, and previous traumas that an individual would have. We need to be very careful not to impose our opinions, biases, or prejudices onto our students, so the aspects of cultural humility that get us to think about this is essential.

It is clear that nurse educators see the value of cultural humility in establishing practices that promote sensitive, respectful, and inclusive care for diverse patients in complex healthcare settings. However, it is important to note that, at no time did the educators describe activities to demonstrate that they were currently engaged in examining personal bias. Furthermore, there was no evidence that they were encouraging students to engage in this type of reflective activity.

This finding strongly suggests that future nursing professionals need to develop new approaches, cultural perceptions, and attitudes through introspection of personal biases. Incorporating interprofessional approaches to reduce bias and promote inclusivity can strengthen the future nursing workforce's ability to engage with evolving cultural differences and foster adaptable approaches, ensuring culturally sensitive and responsive care.

5.4 Current Approaches to Teaching Cultural Diversity in Nurse Education

Another important finding from this study highlights educators' existing practices and approaches to teaching cultural diversity. This section focuses on nurse educators' current teaching strategies and the challenges they face when teaching sensitive issues related to cultural diversity.

5.4.1 Adopting the Individualised Model to Teaching Cultural Diversity

This study has highlighted that none of the participants follow a cultural diversity framework in their practice. Instead, they prefer to adopt the individualised model in their teaching, which encompasses elements of cultural diversity. May explains the individualised model as follows:

> Individualised care is what we teach …. we teach our students how to gather that information about their individual needs and then it's about the communication and the relationships that you build them around the assessment of the patient and the rapport you develop with them.

To some extent, their view of this model reflects the ethos of person-centred care, where the unique values of patients and families are recognised and respected in care planning. They describe a holistic approach to nursing care, suggesting that the care plan includes the diverse needs of the patient. Kirsty provides an example of this:

> I cared for an Aboriginal patient at one time, and he was a brilliant artist, but he couldn't be in a room with more than one person. That was his belief. I suppose it highlights the importance of recognizing little differences in both ourselves and the populations we serve.

Linda and May also feel that the individualised approach to care planning allows them to teach the importance of respecting the unique beliefs and values of the patient and their family. Ciara, Joy, and Kirsty believe that the individualised model can consolidate student learning by recognising the uniqueness of each hospital visit for a patient. This uniqueness is characterised by individual circumstances, cultural backgrounds, personalities, and specific needs. The approach fosters an appreciation of individual experiences and differences that becomes central to tailoring specific culturally sensitive care planning. Therefore, using the individualised approach ensures that care plans are solution-focused but also personalised for each individual.

However, it is important to note that some participants questioned the effectiveness of the individualised approach in terms of addressing cultural diversity needs. Linda states:

> The appropriate standard is treating everybody as an individual, but we might not address diverse issues like, sexual orientation, or anything that has variance in the human being.

This indicates that current perceptions of individualised care might not always meet the specific diverse needs of patients, as Emma explains:

> So, I think, once you have the individual care, you have to delve deeper into that individual, their culture, needs, and requirements that they have so it's not just about individual care but there are loads of variables within that individual care in terms of culture and diversity.

Emma and Linda believe that difficulties with incorporating diversity into the individualised approach can also be related to how individual educators interpret and apply the model in their practice. Joy concurs stating:

> Apart from race even with individual approaches I don't always consider the feelings of an individual that may have a different sexual orientation for example… as to how they may feel clinically when we're when we're looking after them.

Without any formal discussions between team members, there is a suggestion that educators are applying approaches to their teaching of cultural diversity that are not always reflective of the diverse needs of patients. Other participants acknowledge that there are assumptions in the department that the sociologist covers the key tenets of cultural care and the diverse needs of the patient. However, there is also a recognition that this is not good practice in teaching cultural diversity and may account for the lack of focus on its inclusion in practice. Linda states, 'there is a high emphasis on the need for sociologists to address it and cover it. That's kind of where that lives and I think we need to probably take a lot bigger ownership of it.'

The lack of collaboration with integrating cultural diversity in nurse education, particularly in the context of using the individual approach, highlights an area that requires significant team efforts in the future. Linda says, 'like we acknowledge that we use the individual approach but much more discussion needs to be involved on cultural diversity and to make it apparent and visible in our documents to give us some guidance.'

These discussions need to include examining current approaches to cultural diversity in the classroom and the nursing curriculum. Nurse educators need to engage in open discussions with their colleagues about cultural diversity and bias, to create a learning environment that promotes new understandings of different perspectives and experiences. As Ciara acknowledges:

> With the individual approach… I mean we can tell somebody about dietary changes or exercise and medication compliance, but we need to understand where the patient is coming from, we need to know what their social and economic status is, we need to know if there are any gender issues to consider, we need to know what their values and norms are.

This finding suggests a need for individuals to engage with cultural diversity more comprehensively, to ensure that inclusivity is a core value in their approaches to culturally sensitive care. Educators also need to examine their interpretations of the individualised care model and how they implement it in practice to ensure that culturally diverse needs are being met. Inclusivity needs to be adopted in every teaching environment, which involves nurse educators examining their teaching practice and strategies to consider new pedagogies that include cultural humility.

5.4.2 Teaching Strategies for Cultural Diversity

In terms of current teaching approaches, participants favour classroom discussion as a strategy to enhance students' understanding of cultural diversity in patient care. Ciara explains:

> I encourage class discussion where students can give their opinions on things and that we have to listen to everybody, and you don't want anybody being mocked or discouraged from speaking… I do think there's an awful lot that we can learn from what the student has to offer even kind of their own personal experience.

The suggestion in this narrative is that discussion as a strategy can encourage shared learning where educators and students can explore different perspectives of cultural diversity. Bob agrees with this strategy, stating, 'Maybe raising those with students, getting them to share their experiences of them, but also sharing I think there's a role for maybe debate and discussion around.' In this narrative, discussion is highlighted as an approach that is effective in prompting students to think about other individuals' differences and their impact on the healthcare journey. Bob continues:

> So, raising that to be a discussion so that they can see how their cultural practice may impact on others, and how other practices impact upon them and getting some kind of consensus as to what the best approach would be when there is maybe a conflict.

The suggestion of possible conflict is interesting as it indicates that the blending of cultures representing different values, beliefs, and attitudes to healthcare may create conflict. These conflicting views need to be recognised and addressed to ensure optimal culturally sensitive care is being delivered.

These conflicts can also occur in classroom settings and need to be addressed to ensure that students are prepared for the conflict that differences can create. Kirsty states:

> When you're ensuring that there is a discussion it's so important that it is nurtured correctly, and that everybody is given an opportunity to speak but it's also about recognizing their cultural identity.

Here, Kirsty is suggesting that these discussions require careful planning to allow students the freedom to talk about their different experiences and opinions without the fear of reprisal. Within this educational setting, contradictory perspectives, ideas, and beliefs can emerge in the presence of cultural discussion and negotiation. It is therefore important that all parties have the opportunity to share life experiences to open up new perspectives on cultural diversity. By understanding the need for cultural negotiation in these contexts educators are better prepared to encourage harmonious and positive discussions in terms of shared learning. The benefits are that new understandings of cultural differences can lead to new interpretations of cultural diversity, which aligns with the concept of cultural humility. It is also an approach that can promote shared learning experiences for both educators and students.

For example, Leo and Bob state that their teaching of cultural diversity are enriched by sharing their experiences of cultural encounters with students from their travels. This type of storytelling in the classroom helps to stimulate conversations on patient differences and promotes personal values that embody cultural diversity. However, other factors are important for educators to cultivate respectful environments where discussion and reflection are central to shared learning experiences. Joy says:

> I think, from a personal perspective, discussion and reflection gives us an appreciation and empathy for individuals and considerations that are appropriate to them.

The suggestion is that classrooms can serve as learning hubs where educators can exemplify core values such as empathy and respect, which are essential to the cultural encounter. Some educators also believe that these environments can consolidate student learning by inviting diverse patients into the classroom to share their experiences. The creation of these environments fosters inclusivity while urging students to explore cultural diversity from multiple perspectives, thereby simultaneously dismantling preconceived notions. In highlighting the learning environment in this way, participants unwittingly appear to embrace strategies for teaching cultural diversity that are commensurate with the central tenets of cultural humility.

Conversations with the participants also highlighted simulation as a potential site for developing new understandings of cultural diversity. Con remarks:

> Simulation might be a good area or a possible area where scenarios could be adapted to include diversity in the laboratory.

Linda acknowledges that simulations are valuable tools for harnessing approaches to culturally sensitive care and discussing issues of diversity. However, it is apparent from the study that nurse

educators do not currently value the potential of simulation practice in addressing cultural diversity. While cultural care is addressed as it arises in simulation practice, individual educators often handle it in an ad hoc manner. Therefore, there is currently no standard collective approach to integrating cultural diversity into simulation practice. However, following their reflections on vignette two, participants recognised the necessity to address this by designing scenarios that reflect patient differences more comprehensively. Nurse educators need to encourage shared experiences from diverse cultural backgrounds to foster a collaborative approach to simulation design that includes a broader representation of diversity, especially in terms of patient care. This requires careful planning to ensure that diversity is included in case scenarios to prompt discussion and reflection on the intricacies of caring for diverse patients.

Educators offered some enlightening reflections from vignette two in terms of teaching cultural diversity in the simulation room. For example, Joy is concerned about the dominant portrayal of Caucasian patients in simulation labs, stating:

> I don't feel that we've been addressing cultural identities appropriately... are we really addressing all our simulations as to the Caucasian patient?

There were also concerns that students were not being encouraged to reflect on cultural diversity during laboratory simulations, as May notes, ‘but also the students engaging in reflection we would all learn a huge amount, from each other.’ In this context, reflection is valuable in encouraging students to engage in critical thinking, discussions, and negotiations of cultural diversity, reviewing actions taken in the context of diversity, and identifying areas for improvement. This finding offers nurse educators the opportunity to continue identifying ways to foster reflection on cultural diversity in simulation rooms.

May is aware of the potential of using role-play to foster engagement with alternative perspectives in the simulation room. She also emphasised the need to encourage students to engage with shared learning experiences. She states:

> We want them to complete role-play in the lab to find out what is the opposition of the other side, you know, what are their thoughts about it.

This study highlights that nurse educators primarily use discussion in an ad hoc manner to engage student learning of cultural diversity. There is a need to encourage them to review their current teaching and simulation practices to consider strategies that can enhance cultural inclusivity and sensitivity in their teaching. By doing so, they can create learning spaces where students can actively engage in meaningful discussions and reflections, contributing to a more comprehensive and effective educational approach to cultural diversity. These findings emphasise that before

educators introduce teaching methodologies that incorporate cultural humility in nurse education, they need to examine their current teaching strategies to ensure that they are embracing innovative methods that will foster inclusivity and diversity.

5.4.3 Concerns Related to Teaching Cultural Diversity

A key finding that emerged from this study related to participants' concerns about teaching cultural diversity. One surprising finding concerned their limited awareness of the diverse needs of students in their classroom and its potential to influence approaches to cultural diversity. Leo expressed this concern stating:

> Now if we don't have the knowledge about something as everyday as student diversity...we can sail along quite ignorant of how we're missing the target on cultural issues with our students.

Nurse educators were often faced with unfamiliar situations in the classroom because of the convergence of diverse perspectives and backgrounds. May elaborated on this point explaining:

> We've seen that over the last number of years, that we're having more students and patients from different backgrounds, so we have to move with the times and be aware of both groups really.

Presently, there is a feeling that nurse educators are not meeting the diverse needs of students, as noted by Bob: 'I think we're just not being inclusive and we're not meeting diverse learner needs.' This perspective highlights that educators need to understand student diversity to cultivate an appreciation of diverse perspectives for other people among students. Ultimately, comprehending the spectrum of diversity in the classroom can nurture student awareness of patient differences, enhancing the delivery of culturally sensitive patient care.

Initially, the emergence of student diversity was concerning, as it could have indicated a deviation from the primary theme of cultural diversity. However, Emma offers a valuable insight, suggesting that comprehension of the student experience, in terms of diversity, is indispensable for enhancing educators' ability to address cultural diversity. She proposes that understanding student diversity not only enhances educators' knowledge of cultural diversity but also helps them refine their teaching strategies to ensure that students are learning to deliver culturally sensitive care. Emma also recognises the need to consider language and dialect in the cultural encounter to promote understanding of patients' cultural backgrounds. Drawing from personal experience, she articulates an incident involving a student with different cultural needs, highlighting how awareness of such distinctions, can strengthen her practice in this regard:

> There was a student from a different culture and I think that she felt like an outsider and she felt that she was treated differently because of her culture. I developed an understanding that the student was probably disadvantaged because of her culture .... especially if english is not their first language .

This suggests that a lack of awareness of student diversity can result in poor learning experiences for both students and educators. Bob emphasises that the lack of attention to student diversity can exacerbate difficulties in addressing sensitive issues in classroom settings, especially without the appropriate knowledge to do so. In general, the findings suggest that without understanding student diversity, educators may lack the ability to make correlations with patient diversity in the clinical area. Emma explains:

> If we do not understand their needs as diverse individuals then we cannot expect them to develop an awareness of the needs of diverse patients.

Therefore, nurse educators in this study are indicating a need to adapt teaching methods to cater to student diversity, creating dynamic spaces of learning that promote inclusivity. By considering student diversity, educators are better placed to promote inclusive learning environments to prepare future nurses to provide culturally sensitive care to a range of diverse patient populations.

One other concern that emerged as an interesting insight is that educators can face generational and power differentials in the classroom, which can influence their teaching of sensitive subjects, such as cultural diversity. Con states:

> So, I mean God knows what the 17 and 20 year-old students think of me approaching them, because we see ourselves as eternally young ..we don't see those barriers, but they are very, very real for the students...It is very important for us to be aware of it.

His narrative suggests that the discourse of cultural diversity changes in accordance with societal shifts, and generational and power differentials can influence educators' understandings of these concepts. The assumption is that age can influence how individuals perceive the world differently and adopt terminology inherent to their specific generation. Educators need to be aware of this in their practice. Linda articulates concern about the potential for cultural conflict arising from different terminology and language use that may offend students. Language is an integral component of culture, and misunderstandings or misrepresentations can inadvertently create conflict in the classroom for educators. Consequently, if educators are not aware of cultural norms, they may use terminology that is considered outdated and disrespectful. Bob explains further:

> I just noticed, for example, the variation between England and Ireland. I notice a lot of students would talk about Black American, whereas in

> England, they would have talked about Afro-Caribbean cultural groups really. So, it's being sensitive to what people use to identify themselves.

Bob's perspective supports the idea that self-awareness is essential for educators and students to deal with these challenges while fostering more positive learning experiences. An awareness of terminology seems to be reliant on individual educators' engagement with topics of cultural diversity and their commitment to staying current in the field.

The study findings have highlighted that nurse educators face concerns such as a lack of awareness of student diversity, generational gaps, and changing terminologies in learning environments when teaching cultural diversity. Encountering these challenges can make it difficult for nurse educators to create learning environments that promote the optimal practice of cultural diversity. Nurse educators have also suggested that conversations with students about cultural perspectives and experiences can highlight conflicting opinions. Reflection on the root causes of these conflicts and their ramifications in teaching cultural diversity is essential.

This study introduces cultural humility as an approach that will allow nurse educators to self-reflect on their practices and approaches to teaching cultural diversity. It has the potential to offer them a way to promote greater student engagement when learning to provide culturally sensitive care for diverse patients.

5.5 Cultural Humility: A Pathway Forward for Nurse Education Practice?

Cultural humility is proposed as a transformative way forward for nurse education to address concerns with the delivery of culturally responsive and sensitive care. This section explores nurse educators' current understanding of the concept, the pivotal role of reflection in their practice of cultural diversity and humility, and the essential support they require to ensure the successful integration of cultural humility into their educational practice. The exploration of these themes will develop insights into the potential of cultural humility as a nursing pedagogy that will enrich the practice of cultural diversity in nurse education.

5.5.1 Current Understandings of Cultural Humility

This study aims to explore participants' understanding of cultural humility and their openness to adopting it in their practice. In our conversations, it was clear that the nurse educators are not familiar with the term 'cultural humility'. However, all of the participants did offer suggestions on the potential of introducing cultural humility in their practice due to their engagement and familiarity with the practice of self-reflection and critique in their nursing practice. Jodie comments:

> Now, I can relate to the whole idea of self-reflection and self-awareness and lifelong learning from other practices and those elements of cultural humility and being very sensitive to all the other people's cultures, traditions, and background.

This suggests that Jodie believes that gaining proficiency in the art of self-reflection can facilitate an easier transition to adopting cultural humility in nurse education. There is also a recognition among nurse educators that, in the current climate, they must begin to apply self-reflection as a primary strategy in cultivating learning environments that nurture inclusive, respectful, and sensitive approaches to cultural care. May makes a comparison to the concept of cultural competence but reflects on the activities of self-reflection and self-assessment, as it is already embedded in her practice. She states:

> I would understand cultural competence and having a knowledge of cultures and people's backgrounds and have an appreciation and respect to them and understanding your own biases and prejudices that you may have, and my understanding about cultural humility is that it's similar but it involves more self-reflection and self-assessment.

Once again, May realises that cultural humility requires a significant effort on the part of nurse educators to ensure meaningful engagement with self-reflection among students and educators alike. It is encouraging to note that educators are aware of the significance of self-reflection in their approach to cultural diversity. This awareness is particularly important in the context of their recognition of the need to engage in self-examination of personal biases. There was an indication that the nurse educators understood the significance of bias examination as part of their role in preparing students to deliver culturally responsive and sensitive care in healthcare. Therefore, they acknowledged the potential of cultural humility to redirect their focus on diversity by emphasising the need for practitioners to examine the influence of bias on nursing practice.

Linda acknowledges the challenge of distinguishing between different frameworks for cultural diversity. However, she seems to align with cultural humility, recognising its role in building self-awareness and directing educators' attention more effectively on diversity in practice. She states:

> To me they're under the one umbrella and I know they're not different concepts ….to me they have that kind of level of self-awareness that I'm aware of my own biases I'm aware of my own knowledge, I'm aware of what I don't know as much as what I think I do know ….that I am focusing my reflection on diversity so to speak.

Interestingly, Linda highlights a time in her practice when she may have inadvertently engaged with cultural humility. She provides an example from her professional experience as a nurse,

illlustrating how a particular practice she observed aligns with the principles of cultural humility. She explains:

> I remember I was working in a paediatric setting and we had a family from France. The little boy was at the end of life and the parents decided they wanted to leave. They didn't want to stay with the child and I just remember we were all Irish nurses and I suppose I probably would use the word horrified. We couldn't understand how they would leave this little baby like this baby was going to die. How would they not stay? And I remember our ward manager speaking with us at the time of the importance of having respect and humility and understanding and empathy towards their culture, and their belief and that to be honest is the one time that stands out my mind for that phrase, cultural humility, because really, I personally had a bias. But I had to try and find it in me to see it from their perspective and respect their beliefs and their values and what they felt was right for their child.

In this narrative, Linda describes a process in which she expanded her understanding of different cultures beyond her cultural boundaries, leading to new insights. She believes that her growing cultural awareness and openness exemplify the central tenets of cultural humility in providing care to patients with diverse cultural backgrounds. While she may not have recognised that she was engaging with cultural humility in this instance, it is evident that she believes it has the potential to transform approaches to different cultural perspectives. Interestingly, Leo finds cultural humility 'self-explanatory,' indicating that he is not daunted by the prospect of integrating it into his practice due to his knowledge and practice of self-reflection and self-examination.

The narratives show that participants reflections on the potential of cultural humility highlight its benefits for the inclusion of practices that can improve the integration of cultural diversity. May sees the advantages of adopting cultural humility to improve the nursing care of diverse patients. She states:

> I think cultural humility is something that we would benefit from as educators and students and all the while helping or improving the care that's delivered.

This aspect is crucial in recognising cultural humility as a practice that can enhance students' understanding of culture and promote inclusivity of individual differences in delivering culturally sensitive care. Moreover, it suggests that cultural humility can offer a more comprehensive nursing pedagogy to developing approaches to culturally sensitive care. Ciara supports this view, stating:

> Then adding cultural humility, you know the time to think about the diverse patient and to think about their own approaches to the diverse patient as well as reflecting on the power dynamic gives an appreciation of the little differences in your patient you know whether you're hearing is

> okay, whether there's a language barrier or not, whether they can understand you or if they have particular needs as a result of being from a different culture.

As previously mentioned, examining bias has been highlighted as central to cultivating responsive and sensitive care for diverse individuals. The participants recognise that cultural humility can provide practitioners with opportunities to explore their personal biases and its potential effects on their practice. Indeed, many of the participants viewed cultural humility as having the potential to facilitate their examination of personal bias and reflect on experiences, which they viewed as essential for developing inclusivity. Ciara states:

> We need to engage with cultural humility more and even on a personal basis we need to be constantly re-evaluating our own experiences and biases all the time to reflect on how they influence our approaches.

In this, Ciara is expressing the potential value of cultural humility in the examination of personal approaches to diverse care. The suggestion here is that educators can adopt cultural humility, as a strategy to encourage reflection on personal experiences and biases to determine how they influence their practice.

Many of the participants demonstrated a willingness to adopt cultural humility as a way to continually review their practice of cultural diversity. Con states:

> I just sort of suggest that cultural humility is a good choice in terms of acknowledging limitations and sort of not going in thinking I have 30 or 40-years' experience, so I'm able to do this. Leave me alone I'll do my own way that's not an attitude that I would profess at all.

The implication is that nurse educators can apply cultural humility principles to assess their practices and establish better approaches and attitudes to their teaching methodologies. This approach could ensure continual engagement with diversity, thereby improving educators' approaches to cultural diversity in nurse education. Both May and Jodie suggest that cultural humility has the potential to improve their teaching, engage student learning, and motivate them to integrate its principles into the curriculum and their teaching strategies. Ciara proposes that cultural humility has the potential to promote increased learning about cultural diversity by encouraging educators to be humble in their practice. She states:

> We can learn so much more about the individual experience about issues of culture and diversity if we become humble through this process as well as adopting cultural humility ourselves.

Leo supports this sentiment, saying:

> I think if we're humble about our lack of knowledge about other cultures we're off to a great start. To me that's what cultural humility is and I think it's terribly important to engage with it as lecturers, but as people as well.

Leo suggests that cultural humility can cultivate an inherent sense of humbleness for practitioners, which he views as a positive attribute beneficial not only to professional life but also in life in general. He states:

> So, I you know it's ironic that humility is the word as I'm still trying to be humbling while saying that I've been aware of the need for cultural humility for quite some time and I do think I practice it.

Leo's perspective is intriguing because, despite his unfamiliarity with cultural humility in nursing practice, he regards humility as a fundamental personal core value in his life. He believes that this value can extend into nursing practice, particularly when nurturing culturally sensitive care.

Nurse educators primarily relied on their practice of self-reflection as a basis for contemplating the integration of cultural humility in nurse education. However, a noticeable lack of awareness regarding how this concept could be implemented in practice was evident. The findings also highlight the necessity for educators to deepen their understanding of the nuanced characteristics of cultural humility, including its capacity to challenge privilege, before authentic integration can occur in their practice. Therefore, significant effort is needed at both individual and systemic levels to successfully engage with transformative pedagogies, such as cultural humility. However, these findings suggest that nurse educators' grasp of the concepts of self-reflection and introspection empowered them to propose the potential of cultural humility in their personal and professional lives. Their acknowledgment of humility as a fundamental value demonstrates a harmony between their personal beliefs and cultural humility, enabling them to advocate for its integration into practice. Consequently, they have provided valuable insights into how the introduction of cultural humility into their practice can benefit the preparation of future healthcare professionals to deliver culturally sensitive care. Therefore, it remains crucial to support nurse educators in cultivating a deeper understanding of cultural humility, encompassing its influence on their practice of self-reflection, to ensure its successful integration into nurse education.

5.5.2 The Role of Reflection

Reflection emerged as a fundamental activity necessary to the practice of culturally sensitive and inclusive approaches in nurse education practice. However, when considering cultural humility as a transformative pedagogy, there was an indication that educators need to refocus their reflective practice on cultural diversity and mechanisms to support it in practice. The value of reflection in

nursing practice is a well-established core value and engagement with life-long reflection for nurse educators is expected. Jodie explains the relationship of reflection to her practice below:

> So, there is a certain amount of reflection and there's learning I suppose it is lifelong learning and for me from it is a case of I need to be more self-aware in my practice.

This life-long commitment is seen as pivotal for educators to develop valuable insights into their professional practice and motivate them to engage in continuous personal and professional development. In this study, it is clear that educators recognised reflection as useful for educators to assess their competencies and limitations when teaching cultural diversity. May highlights this:

> I suppose the whole thing about cultural competence and humility is about identifying and self-reflection on yourself and your own knowledge and abilities and inabilities.

Emma, Linda, and Joy are aligned in their perception that self-reflection allows them to apply a more critical lens to their practice, curriculum choices, and overall approaches to cultural diversity. This suggests that self-reflection and introspection are necessary for nurse educators to refine their teaching approaches to meet student's learning needs in this area. However, there was also a suggestion that the heightened self-awareness emphasised in cultural humility can empower them to address their limitations and to ensure that their approaches are more inclusive of diversity. Con further validated the value of reflection, favouring it over traditional classroom learning as a more constructive strategy to provide significant learning opportunities for educators and students in addressing misrepresentations of culture.

May and Jodie both hold the belief that reflection is indispensable for their understanding of diverse cultures, particularly in regions where their expertise is presently lacking. Their narratives suggest that self-reflection can help educators develop an understanding of how their own cultural beliefs and background can shape their behaviours, perceptions, and attitudes, towards the practice of cultural diversity. These new perspectives foster a personal engagement with developing an appreciation of multiple perspectives and in challenging preconceived ideas of culture and identity. Bob states:

> We are talking about reflection and I think that's where it should be embedded in the educator role and reflecting on how our teaching, what we teach them, how we teach them and ensuring it involves cultural representation and different perspectives.

This underscores the importance of critical self-reflection in delving into the various facets of cultural diversity and seamlessly integrating them into practice. Nonetheless, the narratives

suggest a need to rejuvenate reflection to encompass cultural diversity across multiple pertinent domains. Therefore, it is crucial to contemplate the integration of cultural humility into their practice, given its foundational principles of self-reflection and self-examination.

Educators emphasise the potential of cultural humility to inspire both educators and students to reflect on their own biases, prejudices, and cultural interpretations. Kirsty states:

> I believe that through reflection, individuals can become more self-aware, recognizing prejudices they were previously unaware of. You know even in terms of things like the constant uses of things like Irish names, for example, that is kind of where I see where cultural humility could be used.

Hence, it's proposed that self-reflection should evolve into a guided practice, encouraging educators to consistently scrutinize their beliefs, biases, assumptions, and cultural perspectives. These efforts can prompt them to reflect on their own cultural beliefs, experiences, and identities within the broader scope of nurse education. Nurse educators seem to suggest that gaining new perspectives through this reflective process can empower them to implement strategies fostering culturally sensitive and inclusive approaches to handling cultural diversity. By nurturing these personal insights and embracing a lifelong commitment to self-reflection and self-examination, educators can enhance their ability to mentor and train future nurses in providing culturally responsive and sensitive care.

Nurse educators also reflected on the importance of nurturing students' skills in practicing cultural humility, particularly in navigating complex situations within diverse healthcare settings. They believe that regular reflection, integral to the cultural humility process, could serve as a pivotal tool in prompting students to evolve into more thoughtful, inclusive, and competent practitioners. This implies that cultural humility empowers them to apply critical and innovative thinking, thereby enhancing their ability to deliver culturally sensitive care. Kirsty elaborates:

> It’s going to enhance best practice when the students are going out with a knowledge of cultural humility embedded into them.

In her reflections on Vignette two, Ciara contemplated how embracing cultural humility could lead to improved learning outcomes for both herself and the students. Her narrative suggests that engaging in critical self-reflection enables individuals to transcend their immediate practice and delve into other factors influencing the integration of cultural diversity within nursing faculties. Jodie underscores the significance of self-reflection for academics, not only concerning cultural matters but also in relation to their emotions and responses to various aspects of practice. She elaborates:

> I believe self-reflection is crucial... It's something I advocate for; we should reflect on how we, as individuals and academics, navigate a range of issues.

The passage suggests that fostering a reflective journey for all practitioners within safe educational environments is essential. These learning opportunities create a dynamic space for reflection, blending various cultural interpretations, backgrounds, and perspectives. Through discussion and reflection, the merging of cultural identities facilitates meaningful exchanges that transform insights into cultural differences. Jodie emphasises:

> Reflection is good especially where there might be a bit of a conflict or might be a difference of opinions and there is huge learning there that people get to talk and get to voice their opinions and get to critique you know and then a lot of resolution will come out of that as well within the group and people feel that they were heard.

All participants said that the need to allocate time and space to reflect is a key consideration to improving personal practice and student learning in terms of cultural humility. The time to reflect was important for daily practice to allow the educator to review what was good and bad about individual teaching sessions with students. May highlights this below:

> As a lecturer you don't have enough time and space to reflect on the good and the not so good and make the improvements for the next time because you're just so constrained.

Jodie felt that a lack of space and time limited the educators in identifying problems and seeking solutions concerning cultural diversity. She feels that having time to reflect is worthwhile to revitalise a focus on implementing teaching strategies that have the potential to support cultural humility, rather than engaging in tick-box exercises. Bob felt that although he did engage with self-reflection, sometimes the busy workload faced by the educator could impede the implementation of cultural humility in practice. He advocated for designated times to be allocated on the timetable to facilitate guided and structured reflective exercises for educators. This would prevent reflection from being treated as an adjunct activity rather than a core strategy to engage educators in improving their practice.

Indeed, both Ciara and Kirsty said that they primarily used their drive home to reflect on the events of the day. Although they are engaged in reflection, they recognised that this was not an ideal practice to initiate any meaningful change. In the extract below, she suggests allowing time for reflection similar to clinical practice, to give educators the space to reflect and to ensure a self-care approach. Kirsty comments:

> I don't think we reflect enough because we don't get the time in a normal day to reflect on issues of culture or diversity in our practice.

The importance of providing space and time for reflection was also recognized as essential for student development and learning. While Joy acknowledged the necessity of reflection, she also perceived the emphasis on exams as hindering the integration of activities supportive of student learning. Joy and Kirsty expressed concerns regarding the prevalent use of a tick-box system to assess competencies in simulation practice. They believed that this approach often limited opportunities for discussing or reflecting on broader issues related to cultural diversity in nurse education. In the extract below Kirsty states:

> And getting students to focus on cultural issues is difficult because we have to cover so much and getting time for reflection is challenging.

There was also an indication that the use of time and space for collaborative reflective exercises between students and educators could improve students' practice. This was seen to be beneficial in terms of using simulation to provide learning of clinical encounters in the healthcare setting. Joy says below:

> Because we're busy getting the job done when we're choreographing our simulations we may not engage with reflection, but it could give us an opportunity to almost kind of pre- analyse anything we do before we do it.

There was consideration given to the benefits of incorporating reflective exercises in practice to facilitate cultural humility, especially related to patient care. Jodie felt that reflection on personal bias was important to engage with before any interaction with patients, to ensure that the student develops a better understanding of their diverse needs. Con felt that the time and space to reflect on cultural diversity would allow the student to be able to meet the challenges that a patient's needs might pose in the clinical area. Bob felt that without reflection, the basic premise of cultural humility, which promotes inclusivity, could be excluded from students' approaches to care. Again, while the participants could easily identify the benefits of cultural humility, to the teaching and learning required to care for diverse patients they also remained aware of the life-long commitment it entailed. In the extract below May states:

> I think that regular reflection would be really great if they have the safe space and the time to do that… it would ultimately benefit the patients and improve their cultural understandings of their patient, which I think is a very worthwhile exercise.

This suggests that fostering self-reflection skills can benefit educators' development and student learning in promoting culturally inclusive and sensitive care. There are considerable benefits in supporting self-reflection for educators in terms of examining their current practice and meeting

the needs of the student to provide culturally sensitive care. This study highlights the importance of self-reflection in nurse educators' practice but emphasises a need for considerable efforts at a systemic level to reinforce the integration of cultural diversity. All participants supported the idea of allocating time and space for both educators and students to engage in self-reflection. Requests for reflection to be included in team activities were common, indicating a shared desire among participants to cultivate a reflective culture within the faculty, thereby enhancing the practice of cultural diversity. Efforts to enhance the development of self-reflection are crucial in the process of integrating cultural humility into nurse education. It can help educators develop their understanding and skill in the practice of cultural humility to enhance student learning and promote culturally inclusive and sensitive care. Despite participants' keen interest in adopting the principles of cultural humility, the lack of systemic support poses challenges to its successful integration into nursing faculties.

5.5.3 Team and Organisational Support

Participants believe that the implementation of new practices espoused by cultural humility requires a commitment from the individual, the team, and the department on a number of levels. Linda feels that the need for support from the team is essential for a successful outcome. She states:

> If you don't get buy-in if the other team members don't see the value in it, people aren't going to want to adopt it.

There is also a suggestion that this approach is now critical, as the current focus on cultural diversity is inadequate in the department in terms of the curriculum, educational practice, and the program in general. Joy states below:

> But there's probably not enough discussion on cultural diversity or how humility might work ….I know what's actually verbalised within our labs as educators, where you know they address these components but they just don't happen to be written into our curriculum or modules or discussed in a meaningful way.

Several participants recognised a deficit in addressing cultural diversity from a team perspective. In the extract below. Ciara says:

> We probably do need to need more as a team to kind of evaluate whether or not we're actually addressing maybe all of what is on the curriculum and that it's being understood by the students as well, or you know the we're all on the same page.

This suggests that there is a need for regular meetings and conversations about the implications of adopting the practice of cultural humility to enhance the delivery of cultural care. Emma raised an

interesting point in terms of the individual effort to integrate cultural humility into nurse education practice. She states:

> Cultural humility talks about things like reflecting on yourself and being more critically aware but I always kind of felt the two words together don't necessarily align…. that might make it more difficult in practice which I could use help with.

Many of the participants advocated for management to support the allocation of time for reflection, discussion, and open discourse on the implementation of reflective exercises to support cultural humility in practice. Jodie advocated for team members to engage in activities that focus on the reflection of bias, beliefs, and limitations before contemplating making decisions on changes to the curriculum. She explains:

> Team members come back and reflect on their own beliefs their own limitations, their own prejudices before we even start then to actually start to discuss incorporating it into the curriculum.

This suggests that individual and collective reflection could inform discussions around institutional practice concerning cultural diversity. Bob felt that team discussion could also focus on bias, especially in investigating if there is continued propagating of stereotypes that could further marginalise groups. May advocates for greater organisational accountability to address systemic issues that contribute to the formation and or maintenance of unconscious bias.

There was acknowledgement that engaging teams in these reflections would be challenging due to the possibility of changes to their practice. Conflict may arise from timetable changes, more emphasis on collaboration, and time commitments for reflection. Participants also identified difficulties in engaging in team discussions about sensitive issues relating to cultural diversity. May states below:

> Yeah there could be conflict there could be you know again you're dealing with a team. So there could be the reluctance to change or the fear of you know the unknown or people not being aware of their own biases or maybe others knowing your bias.

This study emphasises the importance of fostering discussions and collaboration focused on promoting cultural humility in nursing faculties. There is an indication that the participants had not thought about the role of the team or management in integrating culturally sensitive care approaches into the nursing program. From this study, they can focus on lobbying for reflective activities and discussion amongst the team and with management to examine current policies and approaches to cultural diversity. The successful integration of cultural humility into nurse education practice relies on collaborative efforts from the team. On an individual level, there is a

consensus that the practice of cultural humility would also pose personal challenges for the educator, which would require adequate training to overcome.

5.5.4 Educational Requirements for Nurse Educators

After reflecting on vignette two, many of the participants felt that they were currently unprepared to teach cultural diversity in their practice. Jodie and Con state in the extracts below:

> I don't personally feel prepared because I don't have the knowledge of all cultures, and although we need to be respectful and develop care that is person-centered and holistic. **(Jodie)**
>
> No, I am not always prepared to teach, but I would do my best to make myself aware, particularly with regard to having an experience in practice to make myself aware of differences in people, related to cultural diversity. **(Con)**

Vignette two demonstrated that, because of their lack of preparedness, nurse educators often meet challenges when teaching certain aspects of cultural diversity, affecting student learning. This prompted them to reflect on factors that can create obstacles when incorporating cultural humility into their practice. Kirsty says, ‘we absolutely need more training on all these issues’ while Leo felt that with the appropriate training educators can reduce ‘how often you miss the target’ in terms of cultural diversity.

Therefore, participants appeared to unanimously agree that there is a need for training to adequately prepare them to teach cultural diversity. Jodie, Linda, and May share the perspective that additional training and support in their practice would help enhance their instructional approaches. Jodie states:

> The first thing has to be education and training… the only way we can do that is through education and training and support and supervision, probably from our peers.

Leo drew inspiration from previous educational programs he attended and felt that similar initiatives needed to be implemented in practice. He joined Jodie in stressing the importance of involving experts with different cultural backgrounds to build knowledge for educators and students. Linda, May, and Bob suggested workshops aimed at developing cultural awareness as part of interprofessional collaboration that would be beneficial for educators. Linda believed that online workshops that incorporated self-reflective exercises could enhance teaching practice, shared learning, and collective ownership. Overall participants felt that educational initiatives to promote cultural diversity and integrate cultural humility, needed to be ongoing to provide support

to educators to explore the most appropriate methods to ensure culturally sensitive care is delivered.

However, they also recognised that educational initiatives would require commitment and support from the organisation and the team. Emma believed that engagement with educational initiatives could improve working relationships to prioritise the development of new pedagogies for cultural care within the department. According to Kirsty, further education could offer the team opportunities to assess current practices and identify strategies for transformation. However, she also acknowledged the potential obstacles due to the commitment required for individual educators to engage in professional development. She states:

> If you are going to review how you are delivering a syllabus and implement change there is going to be continuous upskilling and training which affects the workload.

Bob also acknowledged that changing practice in terms of cultural diversity is a significant undertaking:

> I think the challenge would be convincing people in leadership and management in the department that this is necessary as part of the role. …getting cultural humility embedded into nursing practice really would be a big thing.

The findings indicate that there is a need for more training and educational initiatives to motivate educators to engage with personal and professional development aligned with cultural diversity. This is particularly pertinent in the event of integrating transformational pedagogies that include the ethos of cultural humility. There is a significant responsibility on faculties and educators to engage with educators and design training programs that will ensure that culturally sensitive and inclusive care remains a core educational philosophy.

5.6 Summary

This chapter shows that nurse educators are aware of the need to change their practice to ensure that patients receive optimal culturally sensitive care. They demonstrate an awareness of the responsibility they shoulder to ensure this is a core value in student learning experiences. They believe that practitioners need to have attributes of kindness, acceptance, respect, and self-awareness and to act with humility when caring for patients with unique diverse needs. An essential part of their role is to develop their self-awareness, especially in addressing bias to ensure that students are prepared to deliver holistic care that recognises issues related to cultural diversity.

The study aimed to prompt the participants to look at the concept of cultural humility, as a suitable approach to prepare students in meeting the diverse needs of service users. All of the participants found the possibility that cultural humility has the potential to be beneficial to their practice, both personally and professionally. Although participants may not have been familiar with the concept of cultural humility, they are aware of the elements of self-reflection and examination, which they use, in their nursing practice. Self-reflection is central to promoting inclusivity and in understanding individual patient's perspectives by promoting active listening and discussion with their student. However, they also raised concerns about implementing cultural humility into their practice, which they regarded as challenging in terms of organisational changes, workload, and individual and team commitment.

With a more structured commitment to cultural humility nurse educators felt that they could prepare students to develop sensitive, tailored, and person-centred approaches to patient care, which ultimately contribute to a positive healthcare experience. However, they also identified that they often lack the knowledge and skills to confidently teach these skills to their students and identified the need for management to support their educational needs to meet these requirements. Ultimately, they felt that cultural humility presents itself as an ethos in nurse education that can facilitate the development of culturally sensitive students who can deliver a standard of care to diverse patients. The following chapter discusses the implications of these findings in the context of contemporary literature.

Chapter 6 Discussion

6.1 Introduction

This chapter presents a discussion of the findings of this study, linking them with published literature to highlight its unique contribution to the field of nurse education. This allows for the exploration of the distinct elements of the narratives of the study, to gain greater insight into this area and link this to current knowledge. The findings provide insightful information that will enhance the delivery of culturally sensitive and responsive care in healthcare environments.

6.2 Current Practice of Cultural Diversity

The findings show that nurse educators feel a significant responsibility to prepare student nurses to deliver culturally sensitive care in response to the changing diversity of Irish society, and its implications for healthcare systems and patient outcomes. This sentiment is supported by numerous professional bodies who have called for the future nursing workforce to be capable of providing quality culturally competent care to diverse populations (AACN, 2021; AACN, 2019; NLN, 2017). Building on this commitment, nurse educators in this study also recognise the need of cultivating a workforce that is committed to diversity and inclusion in their field. To achieve this, participants recognise a need to improve their cultural diversity skills. This is essential for reinvigorating efforts to integrate diversity and inclusion into the nursing program and faculty philosophy. Existing literature has emphasized that nurse educators often feel unprepared to teach cultural diversity due to a lack of proficiency in cultural competence (Paric et al., 2021; Antón-Solanas et al., 2021; Papadopoulos et al., 2016). Findings from this study reinforce the importance of enhancing these skills, emphasising their crucial role in enabling educators to fulfil their responsibility of preparing students to deliver culturally responsive and sensitive care. While reflecting on their current practices, nurse educators in this study recognised a pressing need to address their knowledge and skills regarding cultural diversity. They acknowledged that enhancing their understanding could contribute to the successful integration of cultural diversity into both their teaching and practice. Indeed, the findings from this study emphasise that nurse educators believe that their ability to influence students' engagement with learning cultural diversity signigicantly depends on their own competency. Nair and Adetyo (2019) acknowledge the lack of research available to make correlations between healthcare education and professional, organisational, or patient outcomes. Nonetheless, this research indicates that nurse educators believe their competency is directly related to their motivation and ability to integrate pedagogies and teaching strategies that will strengthen their ability to prepare students for culturally diverse care. This study offers invaluable insights into how nurse educators' competency and practice can be improved to ensure that cultural diversity remains a core priority in nurse education. The

findings also clearly reinforce the imperative for nurse educators to improve their skills in cultural diversity. Doing so is not only crucial to fulfilling their role as educators but also serves as a way to strengthen the inclusion of diversity, equality and inclusion (DEI) into nursing programs.

Notably, the findings indicate that nurse educators clearly recognise the importance of prioritising the development of their skills, knowledge, and understanding of cultural diversity in their practice. They assert that engagement with continuous professional development in this area should take precedence before introducing any transformative initiatives. Many participants expressed deep concern about their insufficient engagement and reflection in integrating cultural diversity when preparing students for evolving healthcare systems. Their discussions indicated that they felt a renewed commitment to developing self-awareness and practicing self-reflection in the context of cultural diversity. Personal development through cultural awareness and reflection is seen as instrumental to enhancing their practice. Participants emphasised the need for future educational strategies that emphasised cultural encounters in healthcare settings, recognising how the convergence of different cultures can influence healthcare behaviours and decisions. All of this indicates that nurse educators clearly recognise the crucial importance of educational initiatives that purposefully engage with self-reflective activities that challenge rigid cultural boundaries and promote the coexistence of multiple perspectives. This also highlights the necessity for dedicated time for reflection, as individuals, with students, and within the team. Support for reflective practices is considered to be multifaceted and includes consideration of proper preparation, structured environments for reflective activities, and dedicated time (Barksby et al., 2015; Wilshaw & Trodden, 2015; Famutimi, 2015). This is important in the context of recognising that reflection is a cognitive, conscious, and intellectual process that examines complex clinical and educational practice (Patel & Metersky, 2022; Lubbe & Botha, 2020).

Reflection, has been long considered a core activity in nursing practice (Lubbe & Botha, 2020), but this is not yet adequately supported by pedagogical and evidence-based research that can better guide its integration into higher education faculties (Donohue, 2019). Although the participants placed strong emphasis on the importance of self-reflection, they did not prioritise reflection in their practice of cultural diversity, and engagement with self-reflection often occurred in an ad hoc manner. A subset of nurses indicated, that self-reflection was often undertaken in an unplanned and spontaneous manner, frequently during their evening commute. This aligns with Naicker and van Rensburg's (2018) assertion that nurse educators may not naturally engage with self-reflection which could lead to a diminished focus on developing the necessary skill set. Other investigations brought to the forefront instances where nurses often suspend their practice of self-reflection,

indicating a need to address ingrained practices in this skill (Asselin & Fain, 2013; Asselin et al., 2013).

Participants expressed concerns about the inadequate attention and provision of resources for reflective practice, advocating for allocating dedicated time to strengthen the message of its importance in developing professional and personal growth for both educators and students. Nurse educators emphasised the need for nursing faculties to integrate reflective activities as a team approach to improve the practice of cultural diversity and when considering the integration of cultural humility. Initiatives to incorporate reflection into faculty meetings or forming groups to reflect on diversity issues could present a united front in prioritising and standardising approaches to cultural diversity. They advocated for educators and management, to explore initiatives that could embed reflective activities focused on cultural diversity into the nursing curricula, programs, and departmental philosophy. Grech (2020) highlights the crucial role of critical self-reflection in the ongoing development of educators, particularly in the field of nursing. Despite various lifelong approaches to learning, the author suggests that a superficial understanding and practice of reflection may result in a focus on technical aspects. Lubbe and Botha (2020) argue that when considering changes in module curricula, practical placements, and the adoption of online teaching methods, the need for critical self-reflection becomes even more significant.

The findings of this study emphasise that a focus on reflection requires continuous support from management. This support involves providing resources, guidelines, scheduled time, and exercises, which is deemed necessary for fostering a lifelong commitment to this practice. Nurse educators believe that such initiatives will ensure ongoing engagement with cultural diversity and humility while harnessing the skills of self-awareness and self-reflection in their practice. While the emphasis on reflection is expected in nurse education, the particular focus on its significance in integrating and practicing cultural diversity is noteworthy, as it fosters an ethos that aligns with cultural humility. The findings of this study affirm the continued need for emphasis on reflection in nurse education, with a specific focus on cultural diversity. This emphasis should be carried out through individual, team, and management efforts.

Despite the prevalence of cultural competence frameworks in healthcare, nurse educators uniformly favour employing the individual model of care to inform their current approaches to cultural diversity. The findings of this research indicate that their interpretation of care within the individual model framework somewhat aligns with the ethos of person-centred care approaches. This alignment connects with the work of Håkansson Eklund et al. (2019), who advocate for a shift to person-centred care (PCC) in healthcare settings. The need to adopt a more person-centred approach to care is now widely promoted to ensure that patients are viewed as equal partners in

healthcare systems (Chapter 3, pg. 43-45). The shift aims to ensure a more holistic, respectful, and empathetic approach to care that is inclusive and respectful of the patient's preferences and needs (Håkansson Eklund et al., 2019). However, the participants tended to use the term 'individualised' instead of patient/person-centred care when describing the approach they advocate when preparing students to care for diverse patients. They often viewed care predominately through a biological, social, and psychosocial lens while appearing to overlook the specific cultural perspectives and needs of diverse communities. When committed to using traditional methods of teaching nursing care, there can be a risk of perpetuating behaviours, perceptions, and practices that are challenging to change. The nurse educators noted that their attention to diversity, culture, and inclusion (DEI) was not optimal and may be compromised because of their individual iterations of PCC models in nurse education. It is also important that nurse educators remain up to date with terminology in contemporary literature if they are to ensure that there is comprehensive incorporation of cultural diversity in their approaches. Mathers and Bansal (2016) noted that interpretations of PCC models may not be compatible with principles that govern the delivery of culturally sensitive care. Markey et al. (2020) suggest that PCC models and cultural diversity frameworks may share the same values but can work as separate and distinct concepts when applied in healthcare settings. The utilisation of two separate frameworks can result in a fragmented and inconsistent approach to culturally sensitive care, leading to poor learning outcomes for nursing students. This study highlights a potential gap in the application of PCC models, indicating a lack of attention to diversity within its framework, potentially impacting the delivery of culturally responsive and sensitive care. Therefore, the findings highlight an opportunity for educational initiatives to recognise the benefits of nurse educators revaluating PCC models with increased awareness to cultural diversity issues.

In examining the conversations among nurse educators, another notable theme emerged, their keen awareness of the influence of their cultural background and personal experiences on their teaching strategies and approaches to cultural diversity. While these cultural influences are predominantly viewed as positive enhancements to pedagogical approaches, concerns were raised regarding the potential for a narrow focus in their practice. They articulated a desire to engage with different cultures, either through professional or personal travels, as a way to expand their understanding of diverse perspectives and enrich their pedagogical approaches. They were also eager to involve students in more immersive programs, not only to augment their teaching methodologies but also to cultivate enriched learning through shared exploration. It is widely acknowledged that immersion programs can yield positive outcomes in student learning, as evidenced by studies such as those conducted by Kohlbry (2016), Browne et al. (2015), and Amerson (2014). Despite this recognition, there exists a research gap in understanding how similar initiatives might contribute to the development of cultural diversity skills among nurse educators. Consequently, the

participants felt that there is a pressing need for nursing faculties to proactively provide such opportunities to educators and conduct thorough investigations into the potential of these initiatives in fostering awareness of cultural diversity within current teaching practices. This research highlights nurse educators'concerns about presenting a narrow view of cultural diversity in their practice. They express openness to opportunities that can broaden their horizons, specifically through immersive programs designed for nurse educators. These initiatives they feel could enrich their personal experiences and foster new understandings of cultural diversity.

This study also shows that nurse educators recognise that it is crucial for them to develop an awareness of student diversity to enrich their understanding of cultural diversity. Gaining insights into student diversity can enhance educators' engagement with cultural differences and foster respect for different values, beliefs, and experiences, inherent to students and patients. As we reflect on these findings, it becomes evident that the acknowledgment of student diversity opens a gateway for nurse educators to create learning environments that are not just academically rigorous but also culturally sensitive and supportive. This aligns with the assertions made by Sathy and Hogan (2019) and Collins et al. (2019), who emphasise the transformative impact of understanding student diversity on the educational landscape. Previous discussions in the literature review (Chapter 3, pg. 50-51) highlight that a lack of knowledge about student diversity can result in suboptimal learning experiences, fostering feelings of isolation and marginalisation among diverse students. Therefore, missed opportunities can exist when educators and students fail to explore the intricacies and complexities inherent in cultural differences in their educational environment. The findings from this study thus highlights a need for nurse educators to develop deeper understanding and insights of student diversity to enrich their understanding of the various aspects of cultural diversity. This new understanding can enable them to improve student engagement, foster respect and pave the way for the creation of culturally sensitive, and supportive learning environments.

6.3 Inclusive Learning Environments

As observed by other researchers (Markey et al., 2020; Malau-Aduli et al., 2019; Perez & Barber, 2018), the educators in my study recognised the need to create safe learning environments to enhance student learning and the practice of cultural diversity. One noticeable difference for nurse educators was their emphasis on the need for these environments to foster values of respect, empathy, and self-awareness and not merely ensure the acquisition of knowledge. Central to this purpose is the importance of ensuring that students can articulate their perspectives and engage in meaningful discussions in respectful and safe environments. This study highlighted that educators often experience many challenges when creating these learning environments and addressing sensitive issues. Narayanasamy et al. (2014) reported that addressing sensitive subjects poses a

challenge for nurse educators and their confidence in doing so often depends on their experience and knowledge. A lack of knowledge of cultural diversity has already been highlighted in this study but participants also discussed other concerns.

This study reveals that some of the nurse educators specifically cite challenges arising from knowledge and generational differences with students when teaching cultural diversity. In particular, these differences can contribute to a lack of familiarity with terminology describing diverse populations. In terms of knowledge, some of the participants felt they lacked confidence in their ability to keep up to date with changing trends and terminology related to cultural diversity. At times this impeded their ability to broach sensitive topics related to cultural diversity as they did not have the necessary fluency in cultural trends or language to initiate discussion. Hart (2017) emphasises the need for educators to develop an understanding of generational differences in the classroom and adapt their teaching strategies to create a learner-centred environment. This research suggests that nurse educators should focus on the unique characteristics of students from different generations and emphasises building a strong relationship between student and educators. Hart (2017) emphasises the importance of nurse educators incorporating interactive teaching methods, such as reflective activities, storytelling, role-play, group work, low and high-fidelity simulation, social media, and learning management systems, to actively engage intergenerational students. Similarly, Chicca and Shellenbarger (2018) propose integrating active teaching methods, experiential learning, technology, and maintaining brief yet frequent interactions with students. Additionally, they believe that learners require support and encouragement for engaging in meaningful dialogical conversations

In the context of teaching cultural diversity, nurse educators in this study identified the use of guest lecturers as an effective strategy to foster knowledge of the needs of diverse populations and break barriers in generating discussions. They believed that incorporating guest speakers, who are experts from diverse cultural backgrounds or practitioners with extensive experience of culturally sensitive care, provides valuable opportunities to engage in discussions about cultural based on personal insights. This study highlights that future educational strategies aimed at strengthening the practice of cultural diversity need to recognise the specific challenges necessary to enhance educators' confidence in handling sensitive topics. This can strengthen their approaches and ability to adopt teaching strategies that will mitigate these concerns.

When reflecting on the concept of cultural humility, nurse educators in my study suggested that it has the potential to guide the adoption of innovative pedagogies in their practice. By embodying the principles of cultural humility, nurse educators appear to suggest that they can better address the needs of an evolving diverse healthcare landscape. This can enable them to act as agents of

change in preparing student nurses to excel in diverse environments. They also recognised that cultural humility can strengthen their approaches and teaching strategies to embrace diversity and inclusivity in healthcare. Similar to Hughes et al. (2020) this study reinforces key considerations that are necessary before integrating new transformative pedagogies such as cultural humility in nurse education, both on an individual and systemic level.

6.4 Cultural Humility in Nurse Education

While the term 'cultural humility' might not have been familiar to these nurse educators, their familiarity with the principles that drive its practice, namely self-reflection and self-examination, allowed them to express a positive yet cautious view of cultural humility. In their reflections, they recognised the potential of cultural humility to transform their practice in preparing students to deliver sensitive care to diverse patients. The core principles of self-reflection and self-examination have been emphasised as essential to the practice of cultural humility from its early conception (Tervalon & Murray-García, 1998) and are also recognised as a long-standing core value of the nursing profession (Jetha et al., 2016). These considerations facilitated their appraisal of cultural humility and their reflections on its applicability in nurse education. The educators recognised the significance of reflection in the development of a scholarship in nurse education and as a guide to best practice, a viewpoint similarly acknowledged by Lubbe and Botha (2020). Although educators do not appear to apply strategies of self-reflection in their teaching of cultural diversity, they do acknowledge its potential to enhance culturally sensitive care principles for both educators and students. The process of self-reflection is a significant factor in facilitating their understanding of cultural humility and evaluating its potential in their practice. Nurse educators also appear to recognise the value of cultural humility in guiding them to model personal values that espouse dignity, respect, and empathy when caring for diverse patients. This implies that they believe that if cultural humility is integrated into the curriculum, it can enable educators to exemplify these attributes, serving examples for students to emulate in their clinical practice. The core values of respect, tolerance, non-judgemental attitudes, and empathy can contribute to strengthening therapeutic relationships in clinical settings.

Foronda (2020), highlighted that flexibility is a key component of cultural humility, empowering practitioners to navigate possible confrontations that can arise from situations where the experiences, values, and beliefs of each individual converge. In these contexts, successful partnerships can be created when there is flexibility on one side to adapt more seamlessly (Foronda, 2020). Foronda et al. (2016) recognised that the practice of cultural humility in healthcare could have many benefits including respectful trusting partnerships, ongoing collaboration, enhanced self-reflection, and lifelong learning. Cultural humility can create

transformative shifts in embedded perspectives, enabling practitioners to approach interactions with diverse patients with humble values (Foronda et al., 2016). This can improve patient compliance, collaboration, and treatment regimens by ensuring that the diverse needs of the patient are included in care plans. This study reinforces this point, as the findings clearly indicate that nurse educators recognise the potential of the reflective and introspective element of cultural humility in nurturing more positive therapeutic relationships in the clinical setting.

Nurse educators in this study also suggested that cultural humility could foster deep understandings of cultural differences, challenging personal biases, and nurturing relationships that have the potential to be more therapeutic with patients, as research also supports (Fisher-Borne et al., 2015; Tervalon & Murray-García, 1998; Danso, 2018; Smith & Foronda, 2021; Foronda et al., 2016; Yeager & Bauer-Wu, 2013). Additionally, participants acknowledged the potential of cultural humility to challenge established interpretations of culture and cultural identities in healthcare and educational practices. This perspective of cultural humility is promising, as it enables nurse educators to adapt their practice to include multiple perspectives, challenge bias, and promote respect for cultural differences through self-reflection. Therefore, the data indicates an understanding of cultural humility as a lifelong process that puts the onus on the practitioner to engage with cultural care, as reiterated by other sources (Tervalon and Murray-García, 1998; Foronda, 2020; Yeager & Bauer-Wu, 2013). This commitment can ensure that the future workforce of nurses transforms its practice to be more inclusive, responsive, and culturally sensitive. Indeed, this study supports the idea that both students and educators can practice cultural humility by becoming more personally humble and responsive toward the diverse needs of patients in healthcare environments. When viewed as a lifelong endeavour cultural humility can enhance both the personal and professional growth for educators, encouraging them to develop self-awareness, confront their personal bias, and set a positive example for their students. This exploration suggests that embedding cultural humility in nurse education is not just a set of practices but an evolving process that creates the space for continuous reflection and growth.

It is important to acknowledge that nurse educators, in this study, support cultural humility in terms of its value in re-energising a focus on self-reflection, cultural encounters, and differences. However, their understanding of the potential of cultural humility in questioning power differentials in healthcare, as well as their understanding of the individual responsibility involved in its practice is currently limited. This limitation can be attributed to their lack of familiarity and underdeveloped understanding of the concept. Fisher-Borne et al. (2015) emphasise the significance of an educator's personal accountability in cultural humility, as it is dependent on introspection and willingness to change. The full implications of personal responsibility did not

seem to be fully understood by educators, indicating another area that needs to be addressed before there is a successful integration of cultural humility in their practice. Hughes et al. (2020) identifies many layers of cultural humility that require educators to embrace both intrapersonal and interpersonal changes if they are to fully embrace it in practice. These entail full recognition of our limited understanding of the perspectives of diverse patients and a willingness to adopt strategies that will ensure respect, empathy, and self-reflection when dealing with diverse patients. Although participants discussed these aspects, it remains unclear if they fully comprehend the requirements and mechanisms necessary to fulfill this role. This demonstrates that an in-depth understanding of cultural humility is required before it can be fully endorsed as a transformative approach to their practice of cultural diversity. To develop nurse educators understanding of cultural humility, a multifaceted approach is required, which includes self-reflection, collaboration, curriculum transformation, and an ongoing commitment to professional and personal development. Without strengthening their comprehension of cultural humility, nurse educators may engage in ineffective practices, impede student learning, hinder personal and professional growth, and inadvertently contribute to poor patient outcomes.

6.5 Integration of Cultural Humility in Nurse Education

There is a consensus, among participants, that cultural humility could be integrated into departmental and institutional policies, program aims, and mission statements at the systems level (Muise, 2019; Schulman & Gingrich, 2017; Tervalon & Murray-García, 1998). Participants in this study perceived a need for future transformative changes, moving beyond an acknowledgment of cultural diversity towards more substantial and intentional actions for the successful integration of new pedagogies. However, echoing the sentiments of other authors, the participants emphasised the considerable efforts required to integrate cultural humility at professional, personal, and systemic levels (Foronda et al., 2016; Hughes et al., 2020; Beagan, 2015). They believed that buy-in from all stakeholders was central to initiatives aiming to integrate any new pedagogy, especially one as complex as cultural humility. Although they recognised this as a surmountable task, it was the time, effort, organisation and collaboration required that appeared daunting to them. While nurse educators recognised these considerable challenges, it is essential to contextualize their perspectives within the broader literature. Previous research by Wang et al. (2018) and Fisher-Borne et al. (2015) has highlighted inconsistencies in integrating cultural competency models in healthcare settings. This suggests that the challenges identified by our participants are not unique to our study but reflect wider issues within the field. However, the participants are adamant that transformation of cultural diversity requires a collaborative team effort if successful integration is to take place.

Although previous literature alludes to the need for collaboration (Hughes et al., 2020) in integrating cultural humility in nurse education, this study highlights the need for small, structured departmental discussions as a first step. However, participants also intimated that these discussions require careful planning, organisation, and commitment from all faculty members to embrace a uniform philosophy. While acknowledging challenges such as time constraints and competing priorities participants suggested that incorporating small discussion forums in existing meeting structures could provide a feasible option. Furthermore, the participants indicated that strategies such as providing adequate resources and time to facilitate faculty development within these meetings are also essential considerations. In this way, they feel that structured discussion can also promote collective ownership and accountability, ensuring a more committed engagement with cultural diversity and humility. This resonates with the work of Hughes et al. (2020), who also propose the creation of collaborative spaces for stakeholders to challenge existing practices and integrate cultural humility policies, thereby fostering a transformative change. Smaller forums, such as those suggested by the participants, could facilitate more meaningful dialogue, the exchange of ideas, and the exploration of strategies to examine cultural diversity and facilitate the integration of new pedagogies in nursing education. These are practical suggestions which can provide guidance for nurse educators who are seeking to adopt transformative pedagogies that prioritise cultural humility in their practice.

Despite advocating for organisational support to improve cultural diversity practices, nurse educators demonstrated hesitancy in actively engaging with the examination of power dynamics, privilege, and the intentions of regulatory bodies. They appeared more comfortable examining their practice and endorsing self-reflection, rather than challenging departmental or regulatory body practices. Other nursing scholars that are engaged with implementing anti-racism or social justice policies in educational practice made similar observations (Bell, 2021; Thorne, 2017; Garland & Batty, 2021). Indeed, the discussion in chapter three relating to dominant discourses (Chapter 3, pg. 41-44) indicates that nurses have long resisted their role in challenging traditional ethnocentric approaches in nursing practice. This is significant for the success of introducing cultural humility as there appears to be a hesitance to examine all facets of practice that can hinder student learning and ultimately patient care. There is a need to enhance nurse educators' engagement with social justice issues by examining their reluctance to examine embedded perspectives and practices in nursing (Drevdahl, 2018). Nurse educators are at the interface of enhancing their practice to engage with transformative pedagogies, such as those that emphasise cultural humility in their practice. However, it is a multifaceted task that will require significant personal endorsement and effort if new pedagogies that reflect cultural humility are to become part of their mainstream practice.

6.6 Nurse Educators Practice of Cultural Humility

Nurse educators identified areas in which they required managerial support to ensure that the appropriate resources were allocated to enhance their professional and personal development. These areas included additional training in teaching cultural diversity, acquiring self-awareness and reflection, developing cultural knowledge, instruction in cultural humility, and challenging unconscious bias. In particular, they sought support to guide practice in examining bias and addressing gender identification, language, and terminology. Warren et al. (2017) found that nurse educators underestimate the significance of developing an awareness of personal bias, especially in the context of their teaching practices. This supports the findings from this study, indicating that nurse educators would welcome educational initiatives that support them in developing and embracing the principles and ethos of cultural humility, especially in the context of examining unconscious bias. Participants suggested that workshops to facilitate self-reflection, and cultural awareness, could provide guidance from cultural experts that would enhance their skills in this area. The literature also emphasises the need for nursing faculties to support educators in integrating innovative approaches and culturally sensitive pedagogies aimed at developing cultural awareness and sensitivity (Markey et al., 2023; Beard, 2016). The findings of this study highlight that continuous professional development is essential to broaden nurse educators' perspectives of cultural diversity and to consider the value of adding cultural humility to their practice. These findings are important to motivate nurse educators to become more involved with policies and procedures to implement the key principles of cultural humility. This study reinforces the need for individual and team involvement in guiding and developing educational initiatives to ensure that diversity, inclusion, and equality remain at the heart of nurse education.

The findings from this study highlight a need for nursing faculties to review the current practice of cultural diversity and identify ways to incorporate transformational pedagogies that embrace cultural humility. Nurse educators need to incorporate pedagogical approaches that are innovative and aimed at broadening interpretations of culture. This can help them in guiding students to engage with multiple perspectives and develop new ways of thinking and practicing.

6.7 Reflexivity

As previously mentioned, reflection emerged as a key theme in the study, encouraging nurse educators to enhance their educational practice in relation to cultural diversity. Younas (2020; 62), posits that nurses can use reflection to examine their attitudes to diversity while considering factors such as religion, race, and cultural backgrounds. Therefore, ongoing reflection on their cultural backgrounds, attitudes, and dispositions can help them recognise the potential of introducing bias into their practice. However, as nurse educators contemplate cultural diversity, they appear to

regard the examination of personal bias as a reflexive process that is essential to their practice, thereby differentiating cultural humility from other concepts. According to Bolton (2005, p. 9), reflection is a process that allows practitioners to examine various dimensions of their practice such as relationships, timing, and location, to develop an understanding of a specific situation or topic. On the other hand, reflexivity involves a more in-depth critical introspection of personal identities and emotions within the boundaries of societal, cultural, and political influences, as well as the lived experiences with others (Skeggs, 2002, p. 360). Nurse educators indicated the need for a more profound reflexive activity to develop self-awareness in the context of their own personal biases, values, beliefs, and cultural identities, as crucial to the advancement of their practice. This perspective is supported by numerous sources as a central ethos of cultural humility in particular (Hook, 2014; Ortega & Faller, 2011; Foronda et al., 2016; Foronda, 2020). This study highlights the significance of developing initiatives that could help nurse educators and students to focus on this reflexive journey especially examining their personal bias. Engaging with cultural humility can facilitate a profound engagement with reflexivity which empowers them in their practice regarding the delivery of culturally sensitive care. They also viewed this skill set as important in the practice of cultural diversity but crucial in nurturing cultural humility approaches. This reflexive process can help both students and educators to identify and challenge biases, preconceived prejudices, and established assumptions. This suggests that embracing cultural humility could offer them an ideal framework to engage with this process, ultimately improving their practice in preparing students to care for diverse patients.

6.8 Exploring Personal Bias

Masters et al. (2019; 628) state that cultivating self-reflection in healthcare workers can nurture cultural humility, mitigate bias, foster empathy, and demonstrate respect for individual uniqueness. As discussed in the literature review (Chapter 3, pg. 37-41), the examination of unconscious bias is crucial to the practice of cultural humility and in recognising their impact on cultural encounters between healthcare workers and patients. According to Edwards-Maddox et al. (2022), this is particularly crucial for enhancing the quality of intercultural communication, which is a key component of cultural interactions. Danvers (2018) also emphasises the importance of student nurses examining their biases through self- reflection to induce an even more profound personal transformation in their caring practices. These study findings reinforce the significance of both educators and students examining their biases, values, and assumptions to enhance optimal practices in caring for diverse patients. As previously discussed (Chapter 3, pg. 37- 41), nurse educators are increasingly encouraged to reflect on their own biases to ensure the cultivation of a future workforce capable of addressing the diverse needs of patients. Markey et al. (2023) acknowledge the existence of implicit biases and their negative impact on intercultural engagement

and integration in the context of postgraduate nursing programs. The study emphasises the importance of recognizing, addressing, and mitigating biases to create a more inclusive and supportive learning environment. This study underscores the equal importance of nurse educators undertaking this examination of bias, especially in the context of cultural diversity. Nurse educators felt that this self-examination can empower them to avoid adopting a monolithic approach to their practice and to refrain from perpetuating discriminatory behaviours in the classroom.

The findings of this study concur with Younas (2020) and Gauthier et al. (2022), that being aware of personal biases can assist educators in avoiding imposing their perspectives on their students. This can ensure that they are nurturing an inclusive, safe, and impartial learning environment that fosters cultural awareness and personal growth. Nurse educators recognised the significance of deconstructing their personal biases and assumptions to enhance their practice of cultural diversity. Indeed, there was ample evidence in the findings to suggest that nurse educators are already confronting personal bias, but often lack the guidance to assimilate this personal learning into educational practices. The development of activities that can encourage them to discuss and reflect on these biases and to explore their impact on their practice would facilitate a more comprehensive integration of cultural humility into their teaching strategies. These activities could also contribute to a more enriching learning experience for both educators and students. The findings indicate that these initiatives can facilitate nurse educators to create an educational landscape that is respectful, inclusive, and accepting and can navigate the complexities caused by personal bias in healthcare settings.

The findings also highlighted the need for nursing faculty and educators to examine how teaching activities can be designed to share experiences, biases, beliefs, and values, to enhance engagement with cultural diversity. This form of collaborative learning can encourage the exchange of diverse perspectives and foster new meanings that can enhance cultural interactions with patients. In examining their bias, educators felt that they could also be motivated to question their influence on their teaching. As an example, nurse educators in this study highlighted concerns about using the correct terminology in classrooms, and the practice of examining bias can be effective in ensuring they do not inadvertently cause offense or reinforce stereotypes. In navigating the cultural and linguistic diversities between students and educators, a more balanced interrogation of their effects on delivering culturally sensitive care can be fostered. Foronda (2020) talks about flexibility and openness as essential qualities of cultural humility and educators need to be proficient in their role to adopt these attributes when initiating conversations about race, language, and ethnicity. This research strongly advocates for nursing faculties and educators to engage with

forums or discussion groups that provide a platform for all parties to participate in critical conversations about bias within a professional community. These collaborative efforts can contribute to personal growth but also cultivate inclusive and respectful learning environments in nurse education, which can foster a future workforce who are adept at navigating and addressing cultural complexities in their practice.

6.9 Teaching Environments and Strategies

The literature shows that fostering safe spaces where cultural differences and personal perspectives can be freely expressed is important in nurse education (Matthew et al., 2018; Smith & Foronda, 2021). This research also shows that nurse educators believe that cultivating environments that embrace cultural differences and multiple perspectives can nurture a sense of humility that will enhance student practice in the delivery of culturally sensitive care. However, despite this, data from this study also indicates that nurse educators tend to rely on a restricted range of teaching strategies when teaching cultural diversity. This can impede the development of such inclusive learning environments and reduce engagement in exploring cultural differences as individuals converge in educational environments.

6.9.1 Current Teaching Strategies

In line with the views of Syafrizal & Pahamzah (2020), participants endorsed classroom discussion as a teaching method that can facilitate student learning of cultural diversity. Nurse educators perceive that engaging in honest and open discussion facilitates student development of culture, enhances their understanding of cultural differences, and allows them to challenge unconscious biases. Discussion as a strategy nurtures a deeper understanding of cultural diversity and supports an ethos of cultural humility. However, nurse educators also recognised the importance of creating learning environments where students are comfortable expressing their opinions and experiences, without the fear of judgment. This indicates that discussions need to be planned and structured to ensure that these sensitive issues are carefully addressed. Other sources have reported that discussions need to be planned and structured so that students can feel safe in articulating their diverse perspectives (Foronda et al., 2022; Chen et al., 2018).

Interestingly, my study indicates that nurse educators do not structure their discussions to include cultural diversity, potentially affecting the effectiveness of student learning. Instead, they tend to adopt an approach to discussion that only facilitates cultural diversity if it arises opportunistically in the classroom. This suggests that nurse educators would benefit from discussions with a focus on cultural diversity to encourage open dialogue about the intricacies involved in caring for diverse patients. Embracing practices that are aligned with cultural humility can encourage respectful debates that explore the intricate relationship between culture and healthcare. Activities such as

small group work, and case scenarios could help to create environments that are more comfortable for students when discussing sensitive issues. These forums could encourage students to engage in discussions on cultural differences, healthcare beliefs, and approaches. As advocated by Smith and Foronda (2021), the implementation of ground rules can be crucial to planning sessions that embrace an ethos of cultural humility. Ground rules can be agreed upon at the beginning of each module or teaching practice to ensure that values of inclusivity, humility, and respect for individual differences are key to the learning experience (Smith & Foronda, 2021). The findings highlight a need for more focused and structured approaches that could support nurse educators to actively improve their discussion strategies which, in turn, could improve students' care of diverse patients. Furthermore, nurse educators should broaden their review to evaluate their use of current strategies and consider integrating more innovative methodologies to promote cultural humility.

As discussed in Chapter 3 (See Chapter 3, pg. 47), simulation is a valuable teaching tool for developing cultural awareness and sensitivity, improving communication skills with diverse patients, and building confidence to address diverse patients in the healthcare system (Qin & Chaimongkol, 2021; Ozkara, 2019; Ndiwane et al., 2017; Everson et al., 2015). In my study, nurse educators realised that their current practice might not effectively harness the potential of simulation in teaching cultural diversity. They regarded simulation as a powerful tool to develop students' cultural awareness, develop an understanding of multiple perspectives of culture, and enhance their ability to deliver culturally responsive and sensitive care in healthcare systems. However, the findings indicate that nurse educators are not presently involved in activities or practices conducive to fostering learning of cultural diversity in educational settings. Indeed, it was evident that cultural diversity issues were only addressed on an ad hoc basis, as they arose during simulation practice. This was also evident from the lack of diversity in the designed clinical scenarios and the predominant use of white manikins.

Nurse educators articulated a willingness to examine their practice of simulation as a strategy with the potential to increase cultural awareness, examine bias, and develop an understanding for both students and educators. Current oversights in their practice carry significant implications for the practice of cultural diversity and warrant consideration if cultural humility is to be incorporated into future practice. Foronda et al. (2018) also support simulation practice using diverse manikins in practice and evidence-based authentic scenarios that are co-constructed with diverse individuals for optimal learning. In supporting the inclusion of cultural humility in simulation practice, Foronda et al. (2018) posit that cultural humility principles need to be embedded in the simulation curriculum, diverse scenarios, and educator practices. This can prompt students to foster candid and open attributes to cultural differences and inform their practice in delivering sensitive care to

diverse patients. These transformed perspectives can inspire students to navigate the complexities of cultural encounters in the clinical area, with increased respect and empathy.

6.9.2 Adopting Innovative Strategies

While a few participants mentioned using visual images, personal storytelling, and statistics to enrich their practice, the findings also indicate an insufficient knowledge of and engagement with innovative teaching strategies to advance cultural diversity. This study highlights a need for a comprehensive review of teaching strategies to enhance the practice of cultural diversity and create a pathway to incorporate cultural humility in nurse education. Nurse educators need guidance and support with the inclusion of teaching strategies that will facilitate the exploration of diverse perspectives, narratives, and cultural experiences into the curriculum and learning outcomes to promote critical thinking in the area of cultural diversity. For example, this could include developing the use of videos and podcasts to share experiences of cultural interactions with diverse individuals; exploring interactive platforms for discussion; and debating the complexities of culture and its relationship to healthcare. By actively encouraging participation in such activities, students and educators can co-create environments that nurture empathy, and respect, to facilitate cultural humility as an approach to transformative growth in caring for diverse patients.

6.10 Summary

Nurse educators are in a privileged position to teach students about the changing diverse landscape in healthcare systems and the patients they serve. They are central to engaging in opportunities to promote DEI in their practice, curricula, and faculty philosophy to ensure that future nurses are prepared to deliver culturally responsive and sensitive care. Nonetheless, the need to review the practice of cultural diversity in nurse education is a key message from this study. Currently, nurse educators seem to practice in silos with little engagement about cultural diversity within their team or faculty. Although they see the value of including DEI in their practice, they demonstrate a propensity to rely on frameworks that are not always conducive to its inclusion across the spectrum of educational initiatives. This study is therefore instrumental in highlighting many initiatives that can motivate them to expand their practice and research focus to be more inclusive of cultural diversity in their practice.

Nurse educators recognise the need to explore new and transformative ways of teaching that will engage their learners with issues of cultural diversity through reflection to enhance their judgment, skills, and practice in this area. This transformative journey requires a considerable effort to be able to understand themselves, their diverse student groups, their attributes, and their approaches to cultural diversity. However, this study indicates that although nurse educators feel a commitment to the practice of cultural diversity they often feel unprepared and unsupported in this

role. To expand their knowledge and practice of cultural diversity nurse educators have acknowledged the need for further education and training. They acknowledge the difficulty with teaching concepts and principles they do not understand themselves, which can significantly impact student learning. Furthermore, collaborative mechanisms need to be established to facilitate policy and procedural changes that promote inclusive approaches when caring for diverse patients and students.

Cultural humility can offer an alternative and powerful approach responding to the complexities of diversity and inclusion in both educational arenas and healthcare systems. It is important to recognize that their understanding of cultural humility was limited to the practice of self-reflection, and thus may not fully embrace its potential. They are fully aware of the complexity of the concept and the challenges involved in integrating it in nurse education practice. This study proposes that integrating cultural humility in nurse education can encourage practitioners to interrogate the self and adopt a humble practice, to ensure that culturally sensitive care is core to their caring role. However, achieving this requires significant effort from both educators and faculty to fully embrace its meaning and promote cultural humility in nursing programs moving forward.

Chapter 7 Conclusion

7.1 Introduction

This chapter builds on the discussions in the preceding chapters by consolidating the diverse strands of my study to provide a comprehensive conclusion. The primary aim of my research was to explore nurse educators' understanding of cultural humility and their perspectives on its potential to enhance student nurse's delivery of culturally responsive and sensitive care. Drawing on my study's findings and on insights from the relevant literature, I will answer the research questions; I will then provide suggestions that can build on a body of knowledge in nurse education, aimed at enhancing the delivery of responsive and sensitive cultural care in healthcare settings. I will outline possible future research avenues that can further knowledge in this field; and I will reflect on the strengths and limitations of this study and on my positionality. These recommendations can offer valuable insights into the potential of cultural humility and teaching strategies that will improve nurse education in this area. The goal is to inspire nursing faculties, educators, and policymakers to consider the concept of cultural humility to transform the healthcare educational landscape, making it more inclusive, equitable, and responsive to the diverse needs of the communities that they serve.

7.2 Answering the Research Questions

In addressing the research questions of this study, my primary goal was to examine nurse educators' understanding of cultural humility and their views on its potential to enhance student nurses' delivery of culturally responsive and sensitive care. The study comprised of two overarching questions, the first question consisting of sub questions to guide my research (See Chapter 1, pg. 12-14).

To investigate the research questions, I utilised the interpretive/constructivist paradigm, conducting ten interviews with nurse educators from my workplace. This qualitative approach prioritised the participants' voices, experiences, and knowledge, placing them at the core of the investigation. This choice aligns with the nature of my research questions, which are best addressed through an exploration of the participants' experiences. Importantly, it also acknowledges my role as an insider researcher without entirely excluding my own perspective.

To enrich participants' contributions, I employed two methodologies; vignettes and semi-structured interviews. Vignettes, portraying scenarios for participants to reflect on, offered a third-person perspective crucial for researching sensitive topics. Semi-structured interviews further delved into vignette-derived data, ensuring triangulation and a comprehensive exploration of research questions. The narratives elicited in the data collection phase provided rich detail of their

approaches to teaching cultural diversity with some wonderful personal and insightful thoughts on their experiences and perceptions of how they viewed their practice of cultural diversity and its relationship to caring for patients with different needs. Undoubtedly their life experiences and inner most thoughts are far more complex than depicted in this study.

I employed Reflexive Thematic Analysis (RTA) as the qualitative research method, guided by Braun and Clarke's framework (2006, 2019, 2020). RTA emerged as an ideal choice for my study, intricately weaving together my subjectivity with the data analysis process. Emphasizing reflexivity, this approach emphasised my active role in examining the nuanced individual experiences and perceptions of nurse educators regarding cultural diversity practices. The organic and reflexive nature of RTA allowed for a dynamic exploration of patterns and themes, steering clear of predetermined frameworks. By recognizing and embracing subjectivity in the research process, RTA transformed it into a valuable resource, fostering thoughtful engagement with the data. In essence, RTA proved to be an accessible, theoretically flexible, and contextually rich approach, significantly contributing to explore the intricate layers of the research questions on cultural diversity practice.

In response to my first question, which aimed to explore nurse educators' understanding of cultural humility, it became evident that although the participants were unfamiliar with this concept, they expressed familiarity with one of its key principles: self-reflection. This enabled them attempt to articulate their perspectives of its potential in their practice. In hindsight, it was not so surprising to find them comfortable with the practice of reflection as it is considered a core value of nursing practice and one in they endeavour to ensure that students are engaged with also. However, it is important to note that this understanding of cultural humility is limiting and does not allow them to explore its full potential in terms of other aspects.

This research study found that nurse educators did not utilise a framework specifically designed for guiding the practice of culturally responsive and sensitive care. Instead they all unanimously approached the practice of cultural diversity by employing the individualised model of care. From my experience, I noted that the individualised approach can sometimes act as a blanket approach, a one size fits all framework that encompasses every aspect of patient care. The study highlights that in the absence of diversity-specific framework nurse educators were often applying the individualised approach in an opportunistic manner, or relying personal experience and values to guide them in their teaching practice. This was apparent by the lack of engagement with cultural diversity in simulation practice where participants seemed genuinely surprised when reading vignette two, which prompted them to reflect on this deficit in their practice. As in insider researcher this is not surprising as I had noticed this in practice prior to engaging in the research.

So, while the participants were praising the study for stimulating their reflections on current practice, I was learning and growing also. A striking fact from this process especially with the vignettes was that educators were prompted to reflect that they did not currently engage with cultural diversity in a meaningful way.

In response to the subsections of question one, which explored whether nurse educators' current approaches align with the principles of cultural humility, it was found that one nurse educator did not apply any of the principles associated with cultural humility in their teaching practice. While they recognised the significance of reflective practice especially in relation to bias they did not currently engage with such practice. However, it would be misleading to assume that the research participants did not engage with any of its principles at all. For instance, Kirsty recalls engaging in self-reflection when the institute transitioned to gender-neutral toilets, which provided her with an opportunity to engage with her own practice of cultural humility. This process of self-reflection on her personal responses to these changes demonstrates a correlation with cultural humility and led to a deep understanding that fostered new interpretations of diversity for her. Similarly, Linda recalled an incident where she inadvertently engaged with cultural humility while working on a pediatric unit in France. These narratives exemplify a genuine engagement with principles that are core to cultural humility and which drive their approaches to cultural diversity. All of their transformative encounters collectively underline participants' willingness to engage with the principles of cultural humility but also highlight a need for a more formal and standardised approach. It was enheartening to know that participants' efforts toward the inclusion of cultural diversity are heartfelt, even though they may not necessarily be structured for maximum effect on teaching and learning experiences.

In relation to question two, which explored nurse educators' perceptions of cultural humility and its potential to enhance their practice of teaching cultural diversity, participants viewed cultural humility's principles as a pathway to promote inclusive learning environments that harness students' diverse perspectives. Nurse educators envisioned that, in these environments, all participants would have the potential for personal development, understanding and growth. The exploration of cultural humility as a valuable tool in creating learning environments was insightful, for the participants, in terms of its potential for transformative learning experiences. As self-awareness and self-reflection are core principles of cultural humility, the participants recognized the potential of these principles to create environments that respect individual differences, listen to every voice, and allow for deeper reflections on cultural diversity. Inclusive environments thrive on principles of shared learning and meaningful partnerships with students and educators to ensure

that values like respect and empathy are central to developing understanding of individual differences and improved cultural interactions.

Nurse educators also perceived that an infusion of cultural humility principles into teaching methodologies had the potential to motivate a deeper introspection of attitudes, biases, prejudices, and stereotypes that are held by the student and educator or perpetuated in healthcare systems. Its practice they observed, can nurture the values and skills to cultivate empathetic, respectful, informed, and culturally sensitive students. Cultural humility thus has the potential to ensure a more harmonious and inclusive experience for the educator, student and ultimately the patient.

The findings also indicate that there are challenges that require attention when integrating cultural humility to enhance learning experiences. Reflecting on teaching strategies was a striking reminder to educators that their own practice was key to practicing cultural humility. Embedding cultural humility into pedagogical approaches creates a series of nuanced decisions and shifts for educators on a personal level. Their traditional teaching strategies may not be planned to focus on cultural diversity which may inadvertently perpetuate cultural bias or reinforce dominant discourses that marginalise cultural perspectives. In their reflections, nurse educators gained a deeper awareness of the need for a systematic review of materials, teaching methodologies, and language employed to ensure that students are engaged with cultural sensitivity. Changing their teaching strategies to align with cultural humility necessitates a paradigm shift to more inclusive, culturally responsive and sensitive approaches. Despite the challenges in this shift, cultural humility provides an opportunity for educators to model qualities of respect, empathy, openness and humility that they seek to instil in students. As this transformative learning unfolds, more inclusive, harmonious and enriching teaching environments are created and learning experiences are driven to move beyond personal cultural boundaries to deeper understanding of individual differences.

As a researcher, I realise that recommending cultural humility in practice is complex and may not be feasible in departments that lack the understanding of the concept or the motivation, time, or buy-in to integrate it. While acknowledging these complexities it remains evident that cultural humility can offer an approach to addressing some of the pressing issues of cultural diversity as highlighted in this study. In answering the research questions this study has demonstrated a need for a significant transformational change to the practice of cultural diversity in nurse education. A transformation that transcends mere procedural adjustments to incorporate an introspective journey for educators and students to ensure that culturally sensitive care is a core value of the nursing profession. Therefore, the study has provided new information for practice and research that can significantly change the landscape of cultural care to meet the global requirements of changing diverse communities.

In advancing our understanding of cultural diversity in nursing education, this study contributes to a critical gap in the existing literature. By exploring nurse educators' perspectives and practices, it unearthed nuanced layers of engagement with cultural diversity principles. The research findings provide a lens into the challenges with the practice of cultural diversity and the considerations and associated problems with the application of cultural humility in teaching environments. While recognizing the heartfelt efforts of educators, this research emphasises the importance of formalizing approaches to cultural diversity for maximum impact. The challenges identified and the transformative potential uncovered by this study emphasise the urgency for a paradigm shift in approaching cultural sensitivity within nursing education.

As this study sheds light on the pressing need for enhanced cultural diversity practices within nurse education, it also paves the way for actionable recommendations aimed at empowering educators and institutions to embrace transformative pedagogies like cultural humility. By addressing these recommendations, nurse education stakeholders can systematically integrate strategies to foster more inclusive and culturally responsive learning environments.

7.3 Recommendations for Future Nurse Education Practice

The findings of this study derive valuable insights from the experiences of ten nurse educators as they navigate a shifting demographic patient profile and prepare students to respond with sensitivity and empathy to cultural diversity. This study makes recommendations for educators and faculties to engage in and create educational initiatives that promote both cultural diversity and humility in nursing education.

A key message from this study is that nurse educators need to reenergize their focus on cultural diversity in nursing education. By integrating comprehensive training on diversity, inclusion, equality, and promoting cultural humility, educators can better prepare future nurses to deliver empathetic, inclusive, and culturally sensitive care, ultimately improving patient outcomes across diverse populations.

Based on the findings of this study, nurse educators should promote inclusivity not only to foster a supportive environment where students feel heard, valued, and respected, but also to inspire them to emulate these inclusive practices in their future caregiving practices. By experiencing and participating in this type of inclusive educational setting, students can develop a deeper understanding of cultural diversity. Thus, an inclusive classroom serves as a crucial training ground where students not only learn theoretical knowledge but also acquire practical skills in delivering respectful and culturally competent care to patients from various cultural backgrounds.

Integrating cultural humility into nurse education can also foster inclusivity by encouraging students to engage with and respect diverse cultural perspectives. This approach better prepares students to navigate complex cultural dynamics and provide culturally competent healthcare. This study emphasises the importance of nurse educators seeking opportunities to promote cultural humility in their practice as a way to become more self-reflective in their teaching practices, shaping a nursing workforce that embodies inclusivity, diversity, empathy, and respect, thereby enhancing overall patient care outcomes.

Nurse educators are professionally obligated to apply the knowledge gained from this research to enhance their practice. These recommendations expand on the study's findings and aim to advance the understanding of cultural diversity, inclusion, and equity in nurse education. They inspire nurse educators and faculty to foster greater inclusion of cultural diversity within nursing programs. A concerted effort is now required from all stakeholders in nurse education to integrate diversity, equity, and inclusion (DEI) into nursing programs, curricula, philosophies, and practices. Therefore, this study highlights the need for nurse educators to prioritise cultural diversity and consider the integration of cultural humility as a foundational principle in their practice.

7.3.1 Promoting Transformative Pedagogies and Teaching Strategies for Nurse Educators

This study emphasises the importance of nurse educators to consider implementing teaching methods and pedagogical initiatives that prioritise inclusivity, fostering an open and inclusive educational environment. This involves adopting diverse teaching approaches that accommodate various learning styles and enrich educational experiences through cultural humility. This approach emphasizes critical self-reflection, awareness of biases, and the development of respectful relationships. Practical methods include developing simulations, role-playing exercises, and community engagement projects that immerse students in diverse cultural settings, including scenarios that reflect the communities they will serve.

The findings of this study supports the need for nurse educators to create safe environments for dialogue in both classroom and simulation practice to establish inclusive spaces that encourage open discussion among educators and students. Such dialogue facilitates the exploration of cultural misrepresentations and biases, thereby enhancing understanding of diverse perspectives. Students should be empowered to critically reflect on biases and caregiving practices to deepen their cultural competence. Additionally, supporting educators through professional development programs can bolster their confidence in navigating evolving trends in cultural diversity with humility and sensitivity.

Furthermore, educators should actively contribute to developing and disseminating educational resources that promote cultural diversity and cultural humility. This involves creating teaching

materials, publishing articles, and engaging in professional forums to share knowledge and best practices in culturally responsive and sensitive care. By integrating these strategies, nurse educators can cultivate a comprehensive and inclusive educational environment that equips students to deliver respectful and culturally competent healthcare.

7.3.2 Commitment to Lifelong Learning for Nurse Educators

Based on this study's findings, nurse educators are recommended to prioritize continuous professional development focused on cultural diversity and cultural humility to enhance the relevance of their teaching practices. This commitment entails actively participating in workshops, seminars, and courses that offer updated knowledge and skills in these areas. Staying informed about new research, emerging trends, and best practices is essential to evolving their understanding of cultural diversity, cultural humility, and related concepts alongside societal changes and field advancements.

Moreover, it is crucial for educators to explore and integrate innovative approaches and methodologies that foster responsive and sensitive nursing care, leveraging new technologies, teaching methods, and assessment strategies. Engaging in collaborative learning with colleagues and professionals from diverse disciplines is also recommended as it provides valuable perspectives and supports a comprehensive approach to cultural diversity and humility within nursing education.

Furthermore, this study recommends that nurse educators need to engage in relevant professional development activities, actively participate in current literature, and seek opportunities for cultural immersion and experiential learning to foster their professional growth. By assuming mentorship roles, they can guide and support new educators, exemplifying a culture of lifelong learning within the nursing education community.

7.3.3 Promoting Cultural Reflection and Reflexivity in Nursing Education

This study strongly recommends that nurse educators need to promote reflection and reflexivity on cultural diversity to foster a deep understanding of biases and enhance cultural humility among both educators and students. Nurse educators are urged to regularly engage in self-reflection to critically evaluate their teaching practices, actively seeking feedback from peers and students to identify areas for improvement and ensure the effectiveness and relevance of their teaching methods. By cultivating a habit of ongoing self-reflection, educators can continuously evolve and adapt their approaches to better meet the diverse cultural needs of their students and future patients.

Central to this reflective practice is the critical acknowledgment and examination of personal biases by nurse educators. It is essential for educators to actively reflect on their biases and areas for improvement in fostering cultural humility. The study findings support the need for nurse

educators to engage in programs, workshops, and literature that enhance their understanding of cultural diversity, equipping educators to integrate these insights into their teaching effectively.

These measures will aid educators in modelling inclusive practices, and encourage educators to create supportive learning environments where students and educators are empowered to challenge their biases. Nurse educators play a pivotal role in teaching students to engage in self-reflection, guiding them to recognize and critically examine their own biases. By encouraging students to reflect on their assumptions and beliefs about cultural practices, educators empower them to develop cultural competence and provide sensitive, patient-centred care. It is therefore crucial, according to these study findings, for nurse educators to find ways to foster this reflexive journey for their students. These initiatives not only fosters respect and empathy but also prepares future nurses to deliver compassionate and culturally sensitive care, which is crucial for navigating effectively within diverse healthcare settings.

To embed inclusive practices across nurse education, this study supports the need to engage stakeholders in ongoing discussions. These conversations ensure that cultural humility can become a central ethos within the curriculum and educational philosophy. By fostering collaborative learning opportunities with stakeholders, including students, faculty members, and healthcare professionals, nurse educators can promote a unified approach to addressing biases and enhancing cultural sensitivity.

Promoting cultural reflection and reflexivity in nurse education necessitates a commitment to continuous self-improvement and the development of inclusive learning environments. By integrating these practices into teaching methodologies and fostering open dialogues with stakeholders, nurse educators can effectively prepare students to deliver responsive and culturally competent care in a global healthcare context. This holistic approach ensures that nurse educators **and their students are well-equipped to navigate and thrive in diverse healthcare settings.**

7.4 Recommendations for the Nursing Faculty

In the field of nursing education, fostering an inclusive environment that embraces cultural diversity and promotes cultural humility is a crucial consideration now. As educators prepare future nursing professionals to deliver sensitive and responsive care, it becomes imperative to embed these principles into the fabric of nursing curricula and institutional practices.

Nursing faculties play a pivotal role in this endeavour by providing the necessary support and resources to empower educators in integrating transformative pedagogies, such as cultural humility, into their teaching methodologies. This involves not only equipping educators with updated knowledge and skills through continuous professional development but also encouraging

reflective practices that enhance awareness of diversity, equity, and inclusion (DEI) within educational settings.

To effectively reinforce cultural diversity as a core philosophy across nursing education, this study encourages faculties to allocate resources strategically. This includes implementing initiatives that infuse cultural humility into the curriculum, teaching methods, and assessment approaches. Organizing workshops and training sessions focused on fostering self-reflection and understanding of cultural humility among educators can cultivate a learning environment where students learn the values of respect, tolerance, and openness toward diverse patients.

Moreover, promoting inclusive learning environments involves proactive steps such as incorporating activities that facilitate interprofessional collaboration and interaction with diverse cultural perspectives. This study supports integrating initiatives such as employing guest speakers from varied backgrounds to teach, which can enrich students' understanding of cultural diversity.

Faculties should also create structured opportunities for educators to engage in reflective practice and update teaching methodologies, enhancing teaching strategies to deepen students' engagement with cultural diversity and humility. Collaborating with stakeholders to promote bias awareness and inclusivity in nursing education further supports these efforts.

Additionally, according to the study findings, nursing faculties are encouraged to engage with stakeholder discussions as they can foster organizational accountability for inclusivity within nursing education. Engaging in conversations with stakeholders ensures that inclusive practices become a central ethos across the board, aligning all parties to the same goals and values.

According to the study findings, nursing faculties need to ensure that they actively contribute to the development and implementation of policies and initiatives that promote cultural diversity, equity, and inclusion within nursing education. The study emphasizes that by engaging with stakeholders and policymakers, nursing faculties can advocate for and shape educational frameworks that foster a culturally responsive and sensitive nursing workforce. This involvement is crucial for aligning institutional practices with broader societal goals of promoting respectful and inclusive healthcare environments.

As nursing faculties advocate for policies that support DEI at the national and global levels, they contribute significantly to creating a robust educational framework that prepares students to navigate the complexities of modern healthcare systems. Their responsibility extends to ensuring that graduates are equipped with the knowledge, skills, and cultural competence necessary to deliver responsive and sensitive care in diverse global contexts. These recommendations aim to equip nursing educators with the necessary tools and strategies to enhance their teaching practices

and cultivate a culturally competent nursing workforce capable of delivering equitable care to a diverse patient population.

7.5 Recommendations for Future Research

This study illustrates that cultural diversity in nurse education is a vastly under-researched domain. In light of this, several potential areas for further development have been identified from the findings. Future research on cultural diversity could usefully focus on exploring the potential of transformative pedagogies that embrace the principles of cultural humility. Here are some recommended areas for further research:

Conduct Longitudinal Studies on Transformative Pedagogies: Undertake longitudinal studies to assess the long-term impact of integrating transformative pedagogies, particularly those rooted in cultural humility, into nursing education.

Evaluate Effectiveness of Pedagogical Approaches Internationally: Conduct comparative international studies to evaluate the effectiveness of various pedagogical approaches, including cultural humility, in promoting cultural diversity and inclusive care within nursing education. By comparing outcomes across different nursing programs globally, researchers can identify best practices and develop evidence-based strategies for integrating cultural humility more effectively.

Adapt Person-Centred Care Models for Cultural Inclusivity: Conduct research that explores strategies to adapt existing Person-Centred Care (PCC) models within nursing education to incorporate a more culturally inclusive approach. This initiative will align teaching practices with the principles of cultural humility, fostering a deeper understanding of cultural sensitivity and inclusivity among educators and students.

Investigate Impact of Educators' Participation in Cultural Activities: Conduct qualitative research to explore the impact of nurse educators' participation in cultural events and activities on their perspectives and teaching practices. Understanding how real-life experiences contribute to the development of cultural diversity and humility can enhance educators' ability to create inclusive learning environments.

Incorporate Activities Promoting Cultural Humility: Explore research methodologies that investigate how to incorporate activities promoting cultural humility within nursing curricula. This may involve interprofessional learning and collaboration with other healthcare disciplines to create opportunities for educators and students to engage with the principles of cultural humility such as self-reflection and examination.

Educate Stakeholders on Bias Awareness: Future research should explore intitiatives that explore and evaluating collaborative efforts to educate management, clinical staff, and educators on bias awareness, fostering inclusive learning environments for nursing students. These research initiatives can promote behavioral change, foster a culture of inclusivity, and guide the integration of the principles of cultural humility in nurse education.

Utilise Mixed-Methods Research: Employ mixed-methods research approaches to gain comprehensive insights into the educational environment and tailor new teaching pedagogies and strategies effectively. By combining qualitative and quantitative methodologies, researchers can explore the potential of transformative pedagogies such as cultural humility while addressing the complexities of nursing education.

Investigate Strategies for Culturally Responsive Teaching: Use mixed-methods research designs to investigate effective strategies for integrating cultural humility principles into nursing education. This research should involve exploring innovative teaching methods, curriculum design approaches, and assessment strategies that promote cultural sensitivity, critical reflection, and inclusive pedagogy among nurse educators.

Evaluate the Impact of Professional Development Programs: Conduct evaluative research to assess the effectiveness of professional development programs aimed at enhancing nurse educators' cultural competence and pedagogical skills. This research should employ pre- and post-intervention assessments, surveys, and focus groups to measure changes in educators' knowledge, attitudes, and behaviors regarding cultural diversity and cultural humility.

Explore the Role of Mentorship and Peer Support: Research should investigate the role of mentorship, peer support, further educational initiatives, and collaborative learning networks in fostering nurse educators' engagement with cultural diversity. This research should examine the benefits of mentorship programs, peer observation protocols, and communities of practice in facilitating educators' professional growth and enhancing cultural competence.

Examine Institutional Factors Influencing Educators' Practice: Use institutional ethnography and organizational case study methods to explore the influence of institutional culture, policies, and structures on nurse educators' practice of cultural diversity. This research should investigate how institutional priorities, resource allocations, and reward systems shape educators' attitudes, behaviors, and decisions regarding diversity education.

These recommendations highlight the need for a multi-faceted approach to research in cultural diversity in nursing education, ensuring that future studies address the complexities and challenges identified in this study. They can also provide valuable information to integrate cultural humility

more effectively into nurse education, serving as a guide to enhancing student nurses' delivery of responsive and sensitive care to diverse patients

7.6 Personal Reflections

Conducting this research has proven to be a valuable educational journey for me on a professional and personal level. A reflexive process allowed me to examine the complexities of the research journey and its procedures both in practical and theoretical terms. The most enjoyable aspect for me was the data collection and analysis phase as it allowed me to immerse myself in the voice and experiences of the participants, a venture I enjoyed.

Conducting this research allowed me to embark on a journey of self-reflection and discovery. I was challenged to confront my perspectives of cultural diversity which caused me to question some of my own embedded beliefs, biases, and prejudices that influenced my practice. I realised that I did not consider the diverse needs of patients as comprehensively as I should have in my teaching prior to this research. I was inclined to rely on one PowerPoint slide that highlights the need to consider culture and diversity in care approaches as opposed to exploring more comprehensively the nuances of diversity equity and inclusion. My personal growth during this study has strengthened my practice of self-reflection in my practice and I now consider more comprehensive ways to embed cultural diversity in my teaching methodologies.

My understanding and awareness of the importance of student diversity have also undergone a personal transformation. Before this study, I was inclined to recognise its relevance on a superficial level, understanding it as a mere assortment of differences in the classroom. Exploring this concept on a deeper level in the study allowed me to develop insight into the intricate layers of student diversity in the classroom. Therefore, I lacked insight into the potential of using student experiences to strengthen their understanding and acceptance and to broaden their perspectives to promote inclusivity in their practice. My future practice will focus on building inclusive learning environments where I can empower students to practice from a non-judgmental stance with empathy, acceptance, tolerance, understanding, and open-mindedness in their cultural encounters.

I must also acknowledge how much I have learned from the positive impact the study had on my colleagues. Knowing that their voices were heard and that they had engaged in meaningful reflection on cultural diversity in their practice was a deeply motivating and rewarding experience for me. To watch colleagues, reflect and learn about cultural diversity and humility was enlightening and heartening in terms of their enthusiasm and drive for their practice and to acquire excellence in this field. This research journey has empowered me to examine professional and personal values, especially in the context of my role as an educator and researcher. These

reflections are a testament to my personal growth; learning and evolution that I have experienced and which will continue to shape my academic, professional, and personal perspectives in my career.

During the research process, I diligently reviewed some theoretical frameworks pertinent to the topic that I hoped might guide my study. While this exploration broadened my understanding, I felt that exploring concepts like cultural competence and humility was complex, and omitting some of the review theories allowed me to gain greater clarity which enabled a deeper exploration of the specific facets that were relevant to the aim of the study. However, toward the end, this decision caused me some self-doubt and anxiety prompting me to take some time away from the study to reflect. During this time of reflection, I recognised that this was a natural part of the research journey. This was confirmed by many conversations with colleagues who had all encountered times of uncertainty and anxiety, especially coming near the conclusion of the research journey. This reflection allowed me to gain confidence and acknowledge that these decisions were not signs of weakness but rather hallmarks of the depth of my investment in the study.

7.7 Strengths and Limitations

Empirical studies must be critiqued for their strengths and limitations as this enables exploration of their validity and is recommended as essential to best research practice (Creswell, 2014; Denzin & Lincoln, 2011).

7.7.1 Strengths of the Study

The use of the interpretive/constructivist approach allowed me as a researcher to interpret the meanings that nurse educators gave to their experiences, their understandings, and interpretations of the world around them. This gave me valuable insights into the participants' values, approaches, and commonalities that were inherent in their practice of cultural diversity. More importantly, it allowed me to position myself in the research while maintaining a degree of objectivity.

The reflexive journey that I undertook throughout the research process is also a strength as it allowed me to examine my values, and assumptions parallel to the participant narrative. Due to this, I became better at critical thinking and developed an awareness of how a reflexive journey was lacking in my practice.

My ability to build a relationship with the participants was crucial to the qualitative research journey. This allowed me to collect rich and meaningful data by creating a safe space for participants to share their experiences, beliefs, challenges, and perspectives on integrating cultural diversity into their practice. Using the rich participant narratives, I was able to make connections

with their different voices to explore how cultural diversity is currently integrated into nursing faculties and the potential to introduce cultural humility. Using two methods of data collection also allowed me to collect nuanced perspectives that enriched my understanding of their perspectives and practices with cultural diversity.

7.7.2 Limitations of the Study

Despite some of these positive elements the study had some limitations. It was a small sample involving only 10 participants, working in one University of 13 institutions offering a nursing programme in Ireland. Therefore, the findings may offer insights and observations that are specific to a particular context and not easily applicable to other settings or populations. This coupled with the interpretivist paradigm may hinder the generalizability of the findings (Mack, 2010). Although I concede that this limits the applicability of my study, it might also encourage others to undertake similar manageable projects in their local environments, as it is a very important component of nursing education in the 21st century.

Although nurse educators are familiar with the underlying principles of cultural humility such as self-reflection, they lack information on its applicability to the overall picture of cultural diversity or how it might be operationalised in practice. This lack of knowledge required me to provide further information on cultural humility. Interestingly, I found that they had engaged with the literature to address their gaps in knowledge on the concept of cultural humility. However, despite these proactive efforts, their practice of self-reflection may not align with the nuanced principles of cultural humility. Cultural humility involves a deeper introspection of biases, personal cultural identities, and experiences which demands a higher level of critical awareness. Therefore, their ability to assess cultural humility in nurse education may not fully encapsulate the potential depth and breadth of its impact on nurse education practice.

Although the interview schedule was carefully constructed, more attention to piloting to a larger number could have provided a depth of focus that could have changed as my journey through the research process advanced and my critical and insightful thinking evolved.

As a researcher endeavouring to answer a pertinent question, using a purposive sample carries inherent limitations that require careful consideration and an awareness of relevant factors, including appropriate paradigms and personal reflective activity. As discussed in Chapter 6, insider researchers may inadvertently introduce pre-existing beliefs and biases into the research process, posing challenges to maintaining objectivity. My assumption that nurse educators were familiar with the concept of cultural humility provides an example of this limitation. This experience has

reinforced my commitment to ensuring that my reflexive practices in my research are more effective in producing more rigorous and unbiased research in the future.

Moreover, it is important to point out and to be fully aware that personal relationships and emotional attachments to the participants can cloud judgment and impede the ability to objectively analyse data or question established norms. To uphold rigor and credibility in the study, I recognized the importance of addressing and acknowledging my personal sources of bias. To mitigate these challenges, I actively engaged in personal reflexive practices, sought external input and validation, and maintained transparency about my insider status. By implementing these strategies, I addressed potential bias and enhanced the robustness of this study.

7.8 Dissemination of the Findings

Dissemination of the findings is an integral component of the research process to ensure that new knowledge is continuously generated and utilised to drive the nursing profession forward. Dissemination will occur in a number of ways, through local, national, and international forums. I intend to present the findings both nationally and internationally at appropriate conferences and to endeavour to submit articles to internationally peer-reviewed journals in the field of nurse education and clinical nursing as a means of contributing some new knowledge to the body of healthcare.

7.9 Conclusion

Although the Irish health service has made significant efforts to meet the healthcare needs of a growing cultural and ethnic diversity, deficits in care for diverse patients are still evident. This has prompted a drive for more system-wide changes that encourage inclusive, responsive, and sensitive approaches in healthcare to address the growing diversity of service users. Nurse educators play a pivotal role in ensuring that future nurses are prepared to respond sensitively to the care needs of these growing diverse communities. Although nurse educators are aware of the importance of cultural diversity in their practice they recognise the limitations of their practice and the requirement to ensure that it is an embedded core value in nursing programs and philosophies into the future. Currently, my study highlights that the participants are aware of the need for more focused, standardised, and collaborative approaches to cultural diversity in nurse education practice. This collaboration in nursing faculties needs to ensure that cultural diversity remains a core value within their programs. When reviewing their current practices nurse educators recognised areas for growth and improvement within current models of cultural diversity in nurse education. The study aim was to focus nurse educators' attention on the benefits of cultural humility as a guiding tool for alternative pedagogies that have the potential to transform their practice and the learning experiences for students.

Initiatives to improve nurse educators' understanding of cultural humility are needed if this approach is to be adopted more widely. However, Wright et al. (2021) remind us that cultural humility involves a more nuanced approach to ensure that diversity, equity, and inclusion consider issues of healthcare inequity, systemic bias, and racism. Therefore, nurse educators need to extend their approach beyond the self to include societal issues and social justice agendas. This would ensure a more comprehensive and inclusive approach to ensuring that diverse populations in healthcare systems are provided with not only sensitive care but equitable one also.

Participants' recognition of the potential of cultural humility as a valuable tool for enhancing the delivery of responsive and sensitive care for diverse patients, demonstrates their eagerness to expand their knowledge and skills in engaging with cultural diversity in their educational practice. Guiding pedagogies of inclusiveness can encourage educators to become more proficient leaders in promoting culturally sensitive care within nurse education and healthcare settings. By considering cultural humility nurse educators can be inspired to consider an approach that fosters respect, acceptance, humility, and empathy in their approaches to meeting the needs of diverse patients and students. By introducing cultural humility in this research study nurse educators recognised it as a potential guide to the introduction of educational initiatives that will promote intercultural dialogue, embrace cultural complexity and difference, challenge power dynamics, and transform learning experiences for students. Despite the significant endeavours that nurse educators and faculties may face in incorporating the tenets of cultural humility into nursing programs, there is a strong willingness to continually work at progressing and enhancing their knowledge and skills in responding to cultural diversity.

As stated previously, nurse educators are in a privileged position to ensure that diversity, inclusion, and equity are at the heart of their practice. This study shows that meaningful action is now necessary for nurse educators to consider the educational opportunities and personal reflexive activities that will promote cultural diversity in nursing faculties. However, my study has shown that they also need to be provided with the necessary time, space, and opportunity to develop their knowledge and understanding of cultural diversity in their practice. Only when they strengthen their understanding and approaches to cultural diversity will they be in a position to embrace the complexities of cultural humility.

By enhancing their understanding of the core tenets of cultural humility and exploring how these translate into practice, educators can then navigate the complexities of providing culturally responsive and sensitive care to diverse communities. There needs to be a concerted effort at a systemic and individual level to develop tailored opportunities for educators to deepen their understanding of cultural humility and its potential to improve their practice. This transformative

process is crucial to re-framing nurse educators' practice to be responsive to diversity in their classrooms and also in the clinical area. It is no longer viable to pay lip service only to diversity within nursing faculties. Nursing educators must follow the growing evidence that supports a need for significant efforts in advancing nursing education in relation to cultural diversity and in challenging continued discriminatory practices in healthcare environments. This study can inform these considerable efforts that will ensure student nurses, as future global partners will be prepared to work in evolving healthcare systems and the delivery of responsive and sensitive care to growing diverse populations. In essence, this research lays the groundwork for a significant transformational change in the practice of cultural diversity in nurse education. By bridging the gap between theoretical understanding and practical application, the findings offer a valuable resource for educators, researchers, and policymakers navigating the evolving landscape of caring for diverse healthcare communities.

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Appendix A: Extracts from Reflective Journal

Excerpt 1

(Reflective Journal, April- May 2020)

I feel strange acting in the role of the interviewer, because of my relationship with my colleagues I know a good deal about the practice of cultural diversity in the department. I have preconceived ideas about how some of them approach the practice of diversity and I am aware of the many deficits in addressing it as a team. I am aware that the simulation scenarios are inadequate in addressing cultural diversity but since I was a team member who devised the scenarios, I am equally to blame in this situation. Therefore, I am very much aware at the outset of the interviews that we are all aware of each other's practices and approaches to cultural diversity to some degree. In the interview, I did not put this out in the open, as I was conscious of my own shortcomings. There were growing tensions in the department, due to managerial changes and I was concerned about the lack of trust between participants and to some degree with me. I am also anxious and concerned because of the environment, that I would not get enough participants to agree to be interviewed. This gave me much pause for thought and I felt had I been more open it would have led to a more equal conversation about deficits in particular. I did adhere to the interview guide as much as I could and I did probe and felt that when I did this there was an openness to share personal opinions and examples. To some extent, I was probably unnecessarily concerned about their commitment to engage with the research. My dual role of interviewer and colleague/friend was difficult but I found myself relaxing more after the initial few interviews. In addition, I have developed an awareness of my own opinions and experiences and their influence on the research. I had to control my urges in the interview to join the discussion especially when reflecting on teaching and simulation practices. As I had been involved in designing the scenarios, I realised that I was largely to blame for the lack of diversity in the patient's stories. I have since rectified this in a module I lead. I also feel that I am learning from listening to the perspectives of others, especially where they differ from my own.

Excerpt 2

(Reflective Journal, June 20th, 2020)

At times, my familiarity with colleagues and my lack of experience in understanding the research interview process affected my confidence in engaging effectively. During the interviews, I became aware that some of my questions may have caused confusion. One participant called me out about how I phrased the questions around privilege in vignette 1. Although I did offer everyone the opportunity for a pre-interview discussion, only one person took up the offer. In one interview, I was openly challenged about my questions related to privilege. I was surprised, as I had extended

the invitation for clarification. However, as the participant began to answer, I realized they had a deeper understanding of the topic than I had assumed. I made a note to ensure future participants had the opportunity to contact me with queries before the interviews. I lost confidence in the interview at this point, and it took considerable time to regain the participant's trust and steer the conversation away from a critical tone. I acknowledge that my thoughts, feelings, fears, and desires affect the interview process, although they may not always be evident in the data or transcripts.

I was upset that this participant had not contacted me before the interview to raise concerns or offer advice. However, I also noted that others were similarly hesitant to answer questions on vignette 1 compared to vignette 2. From my own practice, I observed that nurse educators often overlook the documentation related to cultural diversity and fail to recognize the dominance of one culture in their instructional design. There have been no discussions about the lack of staff diversity or the entrenched Caucasian influence on nursing practice in the department for nearly two decades, suggesting a need for examination. Consequently, I learned a great deal from this interaction and would now put more effort into clarifying points on vignette 1 to ensure participants understand the questions and provide richer data.

Despite my inexperience with vignettes, I chose to refrain from imposing my interpretations on participants before the interview. I included this journal entry in my final methodology chapter to offer transparency into my reflexive journey and demonstrate the importance of cultivating a collaborative and supportive interview environment.

Excerpt 3

(Reflective Journal, June – July 2020)

The beginning of the data analysis journey was disappointing. I found that the college would not be able to set me up with NVivo until September, and technical support beyond June was unavailable. I was anxious to complete the analysis before returning to work in September, knowing I wouldn't have time then. Additionally, I realized I needed to update my skills to use NVivo, which would be time-consuming. However, I see this delay as advantageous as it allowed me to become more immersed in the data. Spending considerable time transcribing the data over the previous two months gave me a good understanding of it, and I thought manual analysis might suffice.

Now, surrounded by transcripts both physically and metaphorically for weeks, I feel somewhat overwhelmed at times but also sense things coming together. Working on data analysis throughout the summer months, I feel somewhat isolated, tired, and disjointed, but I hope connections will soon emerge in my mind and writing. Continuously returning to the data ensures the participants' narratives are heard. My supervisors have been constructive and supportive, advising me to

continue without NVivo, which boosted my confidence. Though progress is slow, I anticipate a sense of achievement when this phase is finished. Overall, this journey phase has been lonely and frustrating. Typically, I have colleagues to seek advice and reflect with, but during the summer months, accessing this support was challenging.

Completing the research and meeting the submission date has been an arduous journey filled with challenges and disappointments. Despite my best efforts, I found myself struggling to keep up with the demands of the project. There were moments when I questioned the decisions made throughout the research process, leading to feelings of frustration and doubt.

Excerpt 4

(Reflective Journal, June – July 2023)

The Covid-19 pandemic profoundly impacted my research journey, prompting a rapid shift to remote methodologies. This adjustment led to significant delays in data collection and analysis as I navigated the complexities of adopting new technologies and digital tools. Securing reliable internet access and mastering these platforms became crucial but challenging aspects of my work. These practical hurdles not only added complexity but also extended the duration of the project.

Alongside these practical challenges, the pandemic also introduced uncertainties regarding the theoretical framework and research methods of my study. Adapting to new constraints required continuous evaluation and adjustment of my research design. I found myself revisiting and refining my approach multiple times to ensure the validity and reliability of my findings under these unprecedented circumstances. This iterative process of theoretical reassessment was essential for navigating the uncertainties brought forth by the pandemic, ultimately contributing to the depth and rigor of my research outcomes.

Reflecting on this experience, I recognize the resilience and adaptability required to overcome these challenges. The pandemic taught me valuable lessons in navigating unforeseen obstacles while maintaining the integrity of my research. This journey underscored the importance of flexibility and perseverance in academic endeavours, preparing me for future challenges in both my professional and personal life.

Appendix B: Codes/Microsoft Comments (Reflective Thoughts)

Vignette 2 example

Int (1): Amm like this is my third year in education and this genuinely, is the first time that I have sat down to think to myself, how am I addressing this within my teaching? What is my process what is my approach? I do not think I should be 3 years in a job before I question something as important if that makes sense (C8a/ C8c)

The participant is questioned about how they address cultural diversity in their practice ~ what approach they use and whether this reflection should have taken place earlier in their practice. I like the fact that the participant has taken the time to think about their role in a meaningful way.

Int (1): So, our cultural patient is probably predominantly Irish, you know, whatever age called a certain name and described in a certain way, and I think that's a default that we go to that we probably need to be more cognizant of, and we need to change (C8f)

Recognises that we tend to use a predominantly Irish cultural patient group, as the template in practice and those educators need to look at changing this. I can resonate with this experience also

Int (2): I probably do, I mean the whole term has already awoken me up to something that I wasn't aware of before (C8a) and I do think it's important in practical's that we address culture amm more than what we're doing absolutely yeah yeah and that we bring it into our teaching more (C8b). I do think you know it is something that yeah definitely on thinking about this scenario and on reflection and to thinking of social inclusion of students and student backgrounds and that (C8b/C8e)

This process has woken up a new awareness about cultural diversity for this participant and acknowledges the need to bring it into their teaching more ~ also the need to be more aware and inclusive of students' backgrounds. There seems to be a lot of personal reflection for the participant here.

Int (3): Well, you see if, as the lecturer going in preparing for the class and if this was a European Caucasian scenario that the students were going to present, I probably as the lecturer then would feel more confident and competent in being able to give them the feedback, then, based on the scenario (C8a/ C8c). Whereas if it was decided that the patient now was going to be from a diverse

background myself the self-reflection part would and the self-assessment part would come to the fore saying that I probably would not have enough or the required information to be able to provide the feedback that's required for the students at the end of that particular scenario. So, I suppose it's all about cultural humility there in that situation would be identifying my own shortcomings (C8e) and then doing something about them (C8a/C8c)

The need to be prepared and competent to deal with this situation is highlighted ~ Educators would be more confident. This is very reflective of my own beliefs on this area of practice.

Acknowledges that on reflection in the face of a diverse patient in a simulation the educator would not have the knowledge/information to provide feedback to the students

Feels that cultural humility would help to identify the educator's shortcomings in relation to cultural diversity. Seems to feel a lot of responsibility toward the student

Vignette 2 example

Obviously, I will just from the point of view of discussing it with colleagues, I think it is becoming more and more important, especially when you see what's going on in the news and even, most recently, you know where people are you know where the whole concept of where you know they're being attacked unreasonably for whatever beliefs they have or whatever way they you know, whatever way they identify themselves, and I suppose you know it's the whole concept of maybe I'm not explaining it correctly, but how we deliver care have to be respectful and it's also about the underpinning educational philosophy and if we get that right, right throughout the curriculum and then it consolidates by having a special purpose module in it (C2e/C2b/C2d/C4a/C4b)

Highlights the need to start discussions on cultural diversity with the team, as it is now a topical and often controversial issue in society today.

Highlights the need to ensure that care is delivered respectfully and underpins our educational philosophy in respect to culture/diversity. I really like these sentiments because they express the need for students to have values similar to the educator

Highlights the need to ensure that cultural diversity is threaded throughout the curriculum and possibly offered as SPA

When you see, I suppose I'm coming from the background of it I think, it is inherent as a nurse as a professional to deliver competent care, irrelevant of the culture and if I thought it was lacking, therefore, then it needs to be discussed and embedded (C1d). For argument's sake, most recently within the department, they bought a mannequin of a different colour to to really you know it's frightening to think that there are professionals who call themselves professionals and wouldn't have this kind of knowledge inherent in their practice or be the advocate properly for the patients. I suppose if this is the case out or if it is coming out of the research, and then there is a moral duty on us as educators, to address this and to put something in place (C2d/C2h/C4a/C4b)

Stresses the importance of professionalism in delivering competent care irrelevant of culture but still it needs to be discussed/embedded in practice

Mentions the use of different coloured mannequins in the labs recently and that it is unbelievable to think that educators may be practicing without the appropriate cultural knowledge ~ it is their moral duty to practice with cultural diversity in mind. I like that this participant has reflected on the need for educators to have a sense of moral duty to students. It shows that the participant thought about the scenario in the vignette.

And I suppose it's a two-way street, from that point of view, and providing the program, linking in with the team ahm when one is devising modules and when one is looking at programmatic review to make sure that it is embedded and as I've said previously it is in the various modules as such (C1d). If you thought it wasn't there before is it time to make it and maybe implement and review it every four years year, every year and build on it as the students go through or have an elective module and honestly with regards to dealing with it or speaking with the team, you know, from once ahh you know it's important it's very important and it's really up to you (C1d/ C4a/C4b)

Highlights the importance of using the programmatic review to ensure cultural diversity is embedded in the modules and the program

Stresses the benefits of offering cultural diversity as an elective module to students

<u>Interview schedule extracts</u>

Int (10): You know, I mean I may actually talk about things within the class about the traveller community, am I talking about how they have a lower life expectancy does anyone even know if one of our students is from the traveling community in the class, no. Am I setting that group, apart from me and from us here in front of us, and sometimes we do that if it's somebody else's problem like longer life or lower life expectancy, well then, it's not my problem. Do I know if I have

somebody in the class that has a mental illness, sure, I don't know that? Okay I am not only expected to know that but is my teaching reflecting the fact that there could be? Maybe not always no does it does cross my mind at times and I do try and you know, ensure that you know I'm respectful if that was the case but, again, I think it's a power thing as well you know it's mean that other groups are in some way lesser or you know if someone has less of a you know a lifespan let's say isn't it great that it's not me. So, we need to be just a little bit more aware of those kinds of things really now, it does cross my mind but not probably enough

Uses the travelling community as an example of marginalised groups that have poor health care access and lower life expectancy

Does not always know about diversity within the classroom ~ which is something that I have experienced also

Is aware of the power imbalance in the class that diversity can create and the participant is careful to be respectful and to be aware of diversities within groups of students at all time

It is great to see that there is a recognition of the importance of personal awareness and respect when teaching about cultural diversity

Int (8): I suppose also how this also I would bring it to my students in role playing and making sure that you would encourage them one would be teaching at all times, mutual respect and going back to where you would see you know group dynamics where that wouldn't be taken place as good as it showed identifying and being able to address it and and ensuring that it wouldn't continue. And I suppose it's about and, therefore, then sort of the students who are the would have other difficulties at being open being honest and providing having the expertise and experience to make sure what resources do I need to ensure that the student gets what they need, and it not where do they need to go.

When facilitating the student in role-play you encourage mutual respect within the group dynamic also. I like that the participant supports the need for respect in the classroom

To ensure that the needs of the students are being met in terms of supports and resources ~ again the need for management to be involved in cultural humility initiatives.

Int (7): So, we need to work on ourselves through a process of reflection and examination to ensure that we are addressing our own, I suppose unconscious biases. And I would always say that to the students as well, they have to stand, apart from what other people's opinions might be, as

well, you have to you have to be you always have to be objective in looking after patients and make sure that they don't feel discriminated against, no matter what they tell you what's the matter what the patient is going to explain to you or tell you. You know it's like even asking people how many cigarettes they smoke, you know you can't be shocked when they tell you, you know you have to that you know you have to you have to leave kind of all your old opinions behind and be open to whatever the patient tells you.

The importance of educators using reflection and examination to address their own unconscious bias ~ this is an important reflection to see here. I think it shows that the participant is aware of the need to be self-reflective first. There is also a recognition of the importance of recognisign bias in their practice ~ this has also stimulated a significant reflective journey for me as a researcher and nurse educator.

The importance of training students to be objective to avoid adopting other people's opinions to ensure that patients are not discriminated against

The important of students having the ability to leave their bias out of the caring role ~ I like that the participant stresses the need for students to be self-reflective/examining also

Appendix C: Vignette One and Questions

As part of a team within the nursing department, you are asked to review the Requirement and Standards document (Nursing and Midwifery Board) to ensure that the current syllabi offered in the degree program are reflective of their requirements. You are the only member of the team who has recently taken part in a course relating to preparing students to care for diverse patients. There are also no members of the team from culturally diverse backgrounds that could represent a multicultural perspective. You notice from the requirements and standards that culture is mentioned six times in the document with respect to;

▪Sociological concepts
▪Health behaviour and the influence of culture and social position on a person's experiences of health and altered health, the person and family in contemporary society; diversity in faith, culture, and pluralism,
▪Nursing the child and young person and their family in a changing society: diversity in faith, culture, and social norms
▪Intercultural communication; Engaging with people of all ages experiencing mental health difficulties at all points across the lifespan, cultures, and context

On reviewing the curriculum document, you question your colleagues about the overall attention to cultural care in the curriculum and with clinical practice classes. You are told that the sociologist has always taught aspects of culture from a theoretical perspective predominantly. In terms of clinical practical sessions, there have been no specifically designed simulations that are specific to patients who meet discrimination based on social aspects of gender/race/age/ sexuality and ethnicity. You are also told that most of the lecturers on the team usually mention it when required in their lectures. This has always been the practice and there has been no motivation or discussion to change this practice now. On reflection, you decide to guide your colleagues to think about changing this practice.

Possible Associated Questions to Vignette 1

•Can you describe your feelings, if you were in this situation?
•What do you think your reaction/ actions would be in this situation? And why?
•Do you see any professionalism dilemma for yourself in the above scenario?
•Do you see any personal dilemma for yourself in the above scenario?
•Do you think there would be any consequences for your decision to approach the team?
•What if you were in the shoes of a colleague?

•Do you feel more prepared to discuss or reflect on preparing students to deliver individual care to diverse groups in terms of their cultural beliefs?
•Do you think it is important after reading this scenario to embed the principles of cultural care in the curriculum more?
•What did you learn from discussing/reflecting on this scenario?
•What are your thoughts on the overall representation of cultural diversity in the NMBI requirements and standards document?
•Do you think that we need to offer training and professional development that address inequalities and encourage active self-reflection about power and privilege?
•Do you have any thoughts on the lack of diverse staff in the department? Do you think that a more diverse representation in the staff profile might result in more engagement with culture in the curriculum?
•What are your overall reflections after reading the above vignette?

Appendix D: Vignette Two and Questions

As part of a group project, nursing students are being assessed using a case scenario presentation. The student group will devise the patient case scenario amongst themselves but you are the facilitator that will guide them through the care of this patient. The group has six members with all members bar two identifying as European Caucasian descent. One other student is of Nigerian descent and the other is of Asian descent, both of which have been living in the locality for over 10 years. In your first facilitative session, you ask the group to write up the scenario and care plan for the patient and you will review it with them before they begin to practice the presentation. When you return to the group, you find that there is a robust discussion occurring about what ethnicity the patient in the scenario should be. Both students from diverse backgrounds are keen to develop the scenario around a patient from a different culture while the rest of the group is exhibiting hesitant behaviours. When you ask the students state that they want to use a patient who is experiencing deficits to the successful integration of their individual cultural needs in a health care scenario. Both students state that although they are in the third year of the program they have never seen such a patient used as a clinical example or discussed in any forum so far in education. They point out that all the lecturers and the majority of students are Caucasian, and that the mannequins in which they have to practice are white with no representation of colour in their practice. They feel that cultural diversity is not being represented in their learning to date and they feel that sometimes it is difficult for them to relate to this content. They see this as a learning opportunity for the rest of the group and they feel that they believe that due to the poor attention to patient groups who are not receiving care that is absent of attention to their cultural needs, they are best placed to inform the group. They state that culture is an essential part of health care and individual approaches to care as well as beliefs about how and where caring should take place. They ask you if do you not believe that culture is an essential element of caring and that all healthcare workers should have some knowledge in relation to it. One of the students explains that in her culture many individuals are poor and have had little access to health care similar to what she has witnessed as a resident in her current home. The rest of the group stated that they are willing to learn but are hesitant because they do not feel prepared to care for patients from diverse population groups.

<u>Possible Associated Questions to Vignette 1</u>

- Can you describe your feelings, if you were in this situation?
- What would you think your reaction/action would be in that situation? And why?
- Do you see any professional dilemma for yourself in this scenario?

- Do you see any personal dilemma for yourself in this scenario?
- From your own personal reflection, do you think you would have been prepared for this scenario?
- What would your own engagement with self-reflection and self-examination as the principles of cultural humility, teach you about this scenario?
- What would be the benefits of cultural humility in this situation? Especially from a personal perspective?
- What problems with the implementation of the concept of cultural humility might a simulation such as this have?
- What are your overall thoughts and reflections on the vignette and the scenario as presented to you?

Appendix E: Participant Information Sheet

My name is Marva Fitzpatrick and I am currently enrolled in a Doctorate in Education program (EdD) at the University of Glasgow. I currently work as a nurse educator in the Department of Nursing and Health Sciences at the Technological University of Shannon, Athlone, Ireland. The research aim of this study is to explore nurse educators' understanding of cultural humility and their perspectives on its potential to enhance student nurse's delivery of culturally responsive and sensitive care.

Research Questions:

1. What are nurse educators' current understandings of cultural humility?

> **1. (a)** What approaches do nurse educators currently adopt (if any) to teach about culturally responsive care?
>
> **1. (b)** To what extent do their approaches and/or the principles underpinning them, overlap with the principles of cultural humility?

2. In what ways, if at all, do nurse educators perceive cultural humility to have the potential to enhance their practice of teaching cultural diversity?

You are being invited to take part in the study, as you are an experienced educator, who has been involved in teaching nursing students in all aspects of care inclusive of cultural issues, for at least two years. Before you decide to take part, you need to understand, why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish. Ask the researcher/s if there is anything that is not clear or if you would like more information. Take some time to decide whether you wish to take part.

Thank you for reading this.

Purpose of the Study

The dissertation is an empirical study situated in an interpretive/ constructivist paradigm (Guba and Lincoln, 1994) to explore nurse educators' understandings of cultural humility and their perspectives on its potential to enhance student nurses' delivery of culturally responsive and sensitive care. For healthcare professionals in clinical practice, a lack of awareness of our cultural perceptions can introduce the risk of a subconscious imposition of our beliefs during patient interactions. Therefore, for nurse educators need to cultivate cultural humility in their practice to

improve attitudes that foster understanding of other cultures which is an essential attribute for healthcare providers working with increasingly multicultural and diverse patient populations

Justification for the Research

Cultural competence has become the dominant approach within nurse education to prepare student nurses to address the deficits to the successful integration of individual cultural needs in health care. Cultural competence is viewed as a congruent set of behaviours, attitudes, practices, knowledge, and policies necessary to care for diverse patient groups (American Association of Colleges of Nursing, 2018). However, this model has been questioned due to an existing belief that no amount of studying culture will ever render an individual completely competent or proficient in every individual culture (Fisher-Borne, et al., 2015; Hook, 2014, Isaacson, 2014). Increasingly personal accountability has become a lifelong process of self-reflection and self-critique that involves learning about another's culture as well as reflecting on one's own beliefs and values (Foronda et al., 2016; Isaacson, 2014).

Tervalon and Murray-García (1998) first coined the concept of cultural humility in their seminal work in medicine, making a distinction between cultural humility and cultural competence. Tervalon and Murray-Garcıa (1998;118) described cultural humility as a process of 'committing to an ongoing relationship with patients, communities, and colleagues' that requires 'humility as individuals continually engage in self-reflection and self-critique.' Both physicians began this discourse in response to the recognition of the power imbalance that existed in sociocultural discrepancies between patient and provider. It was designed as a lifelong tool that encourages engagement with the processes of self-reflection and critique to redress power imbalances that existed between physician and client (Danso, 2018). This entails moving beyond the mastery of skills inherent in competency approach models (Isaccson, 2014) to engage in the practice of self-reflexivity advocated by the cultural humility approach. I hope this study will prompt nurse educators to examine the understanding of how cultural humility can help them to recognize and guide students in reducing power relations, and healthcare inequities that are produced in the health system, and to exhibit sensitivity to the impact of power differentials on cultural and diverse patients. It will also allow them the opportunity to reflect on strategies that can be incorporated into their teaching practice and nursing curricula that can better help them prepare future nurses to deliver cultural care to their diverse patients.

Participation in Data Collection

I wish to emphasise to you that participation in this study is voluntary. You have the right to withdraw from participating in the research study at any time without providing a reason. Withdrawing will not prejudice your role in the nursing department nor result in any personal repercussions. I am also aware that the nature of the topic may entail a degree of sensitivity and risk and I wish to ensure you that I aim to protect your well-being at all times throughout the process. Should you agree to participate you will be asked to read and respond to two vignettes and to participate in a semi-structured interview. The vignettes and interview guide will be sent to you a week in advance of the interview, which I hope will allow you adequate time to read and reflect on their content. The interviews will include an interview guide, which will also include questions about your thoughts and reflections on the vignettes.

Due to the possibility of government guidance and restrictions on the working practices within the participating College, I will use Zoom as a platform for carrying out the semi-structured interviews with you, which I plan to record. I am aware that you are inviting me into your home so wish to emphasise that if you feel uncomfortable being filmed you will be able to switch off the video stream so only the audio is used or alternatively use a digital background if you wish. The interviews will be recorded on my University of Glasgow Zoom student account, which can only be accessed by me. This service is free to all doctoral students with access only granted to registered students in the doctoral program at the University of Glasgow. The recordings will be downloaded immediately and encrypted by myself. The audio-video recordings and transcripts will then be deleted. Paper notes such as transcribed transcripts and/or printouts that are used through the transcription and analysis stages will be stored in my office in a locked filing cabinet, which is only accessed by myself. It will be shredded and placed in confidential waste by January 2023. All other data (including transcription of interviews) will be stored on the University of Glasgow One drive and on my personal laptop, which is password-protected and only accessed by myself. This data will be retained and disposed of in line with University protocols or until any papers associated with the study are published within 5 years of completion. I will attempt to collect as little personal data as possible and only that which is required for the study. Both the vignettes and the interview guide are worded in such a way that personal data will not be collected during the interviews. All essential personal data collected (e.g. contact details) will be stored on a password-protected laptop, which only I as the primary researcher will have access to. I intend to code any identifiable data that will be used in the study by allocating codes. All other personal data will be destroyed once de-identification, has been completed.

To maintain confidentiality, during the transcription of the audio data, identifiers such as names, places, links to subjects taught, times, and previous occupations, are replaced by codes to prevent identification of you as a participant as far as reasonably possible. The data generated during data collection will be made available for your inspection on request. The transcriptions will be analysed using an inductive reflexive thematic analysis of six stages, as described by Braun and Clarke (2019). As an insider researcher, I will remain aware of the element of reciprocity that may occur and I will endeavour to promote reflexivity throughout. Written evidence of consent, through a signed consent form, will not be obtained due to logistical issues relating to the remote interview method. I will share the information sheet and the consent form on Zoom with you before the commencement of the interview to ensure you have understood the key principles of participation. The online interviews will be arranged and conducted at times that are convenient for you as a participant. The interviews will take place in an eight-week window, with interviews organised in the first week, so there are other opportunities should the interview need to be postponed. The interview will take approximately 45-60 minutes but if you wish to continue past the allotted time, I will continue only if permitted by you. The interview guide will also be shared with you in advance of the interview dates.

Should distress occur because of a discussion relating to your beliefs and values or any issue, the interview will be paused, or you can change the subject, or stop the interview. All requests from you at this point will be accommodated and I will only return to the interview at a time that is requested by you. You are also encouraged to avail yourself of the employee assistance services, which offer free counselling to all members of staff. I will discuss and continue to discuss with you, ways to mitigate any possible stressful effects of the interview on you. If issues relating to the COVID-19 situation or general issues relating to the stresses in the workplace or personally are raised, I will respond to these with sensitivity, I am an educator who works in the same college and I am also experiencing the implications of work changes and stresses, as a result of changes to the teaching/work environment.

This research study will only commence when all details concerning the study and ethical issues have been considered and approved by the College Research Ethics Committee and the Ethics Committee at the Technological University of Shannon (TUS), Ireland.

If you have any further queries or concerns about this research study please do not hesitate to contact the relevant individuals below;

Marva Fitzpatrick (EdD student and primary researcher) xxxxxxxx@student.gla.ac.uk

Dr Giovanna Fassetta (Primary Supervisor) Giovanna.Fassetta@glasgow.ac.uk

To pursue any complaint about the conduct of the research; contact the College of Social Sciences Ethics Officer, Dr Muir Houston, email; Muir.Houston@glasgow.ac.uk

Many thanks for your support and participation in this trial study,

Regards,

Marva Fitzpatrick

Lecturer, Department of Nursing and Health Sciences,

TUS, Athlone.

Marva.fitzpatrick@tus.ie

Appendix F: Interview Guide

What framework do you currently use as a guide when preparing students to care for diverse patients?

What principles and approaches do you use when teaching students about the care of patients from diverse groups?

Have you heard of the concept of cultural humility in your professional life?

To what extent do you understand cultural humility as a concept?

To what extent do you think your current approaches and practices reflect the key principles of cultural humility?

How do you think you can be supported to embed cultural humility into teaching practice?

Cultural Humility entails a long-term commitment to the practice of self-assessment and self-reflection to enhance your own approach to cultural care. Do you think this method has advantages? Do you think this method poses challenges for you?

Cultural humility asks us to reflect on our own culture, beliefs, and values in terms of how they might influence our practice. Do you practice any element of these processes? If so in what way?

What do you think that adopting the concept of cultural humility can add to your practice?

What advantages do you think your engagement in cultural humility might have for your students?

Do you ever question current practices in your Department concerning cultural care?

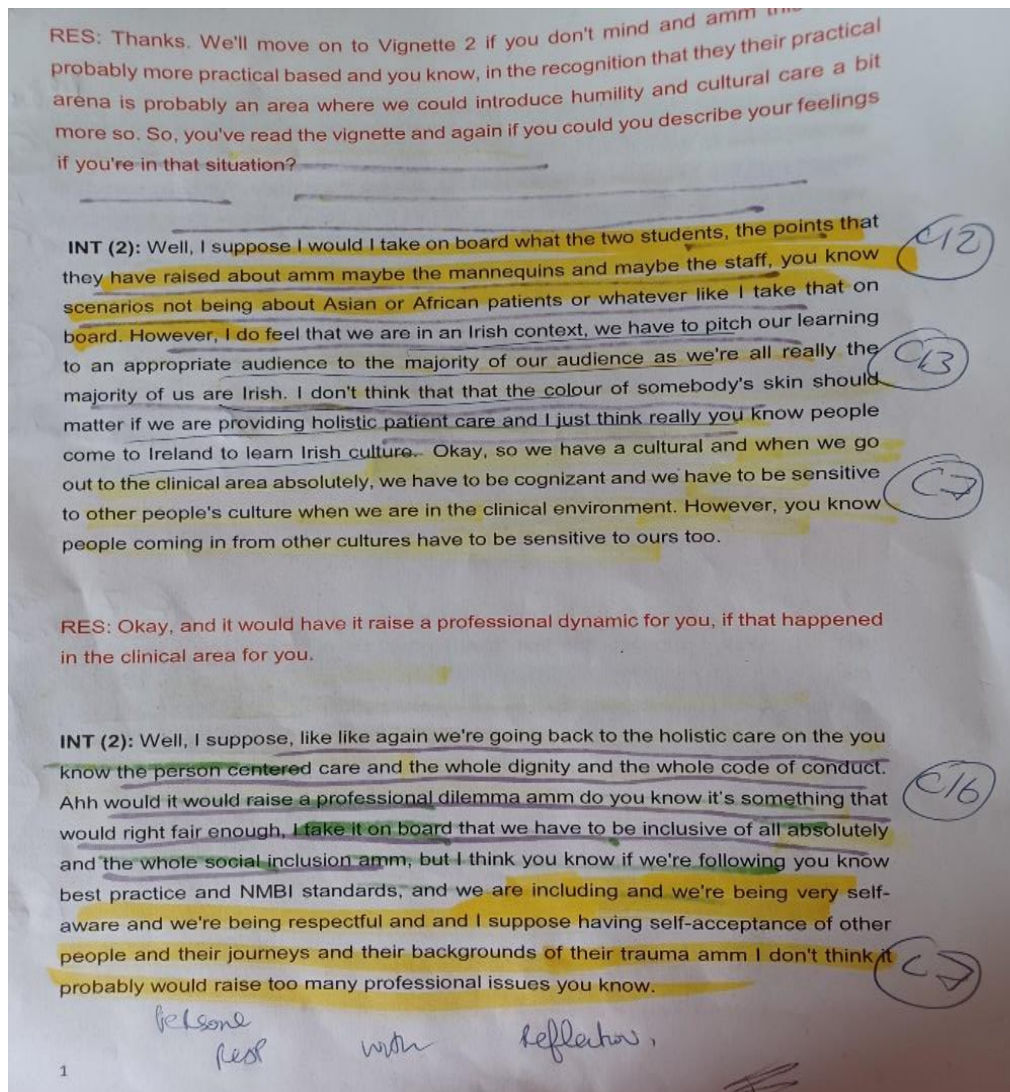
Cultural humility asks us to reflect on dominant discourses such as the emphasis on competency and assessment in our practice. Have you ever done this? If so, what do you see as being the dominant discourses and how can the focus in these areas affect how cultural care is approached in your institution?

Does the culture in your department encourage respectful, substantive discussions about difference, oppression, and inclusion in terms of teaching strategies, diverse student bodies, and curriculum content?

Do you think that the current policies in your department are teaching students to care in a way that reflects the communities they serve?

Have you any final thoughts or reflections on the concept of cultural humility?

Appendix G: Coding Phase 1 (Messy Phase)



RES: Thanks. We'll move on to Vignette 2 if you don't mind and amm probably more practical based and you know, in the recognition that they their practical arena is probably an area where we could introduce humility and cultural care a bit more so. So, you've read the vignette and again if you could you describe your feelings if you're in that situation?

INT (2): Well, I suppose I would I take on board what the two students, the points that they have raised about amm maybe the mannequins and maybe the staff, you know scenarios not being about Asian or African patients or whatever like I take that on board. However, I do feel that we are in an Irish context, we have to pitch our learning to an appropriate audience to the majority of our audience as we're all really the majority of us are Irish. I don't think that that the colour of somebody's skin should matter if we are providing holistic patient care and I just think really you know people come to Ireland to learn Irish culture. Okay, so we have a cultural and when we go out to the clinical area absolutely, we have to be cognizant and we have to be sensitive to other people's culture when we are in the clinical environment. However, you know people coming in from other cultures have to be sensitive to ours too.

RES: Okay, and it would have it raise a professional dynamic for you, if that happened in the clinical area for you.

INT (2): Well, I suppose, like like again we're going back to the holistic care on the you know the person centered care and the whole dignity and the whole code of conduct. Ahh would it would raise a professional dilemma amm do you know it's something that would right fair enough, I take it on board that we have to be inclusive of all absolutely and the whole social inclusion amm, but I think you know if we're following you know best practice and NMBI standards, and we are including and we're being very self-aware and we're being respectful and and I suppose having self-acceptance of other people and their journeys and their backgrounds of their trauma amm I don't think it probably would raise too many professional issues you know.

1

RES: And there's a long-term commitment embedded in cultural humility through the practice of self-assessment and self-reflection to enhance your approach to everything but, including cultural care, do you think this has advantages.

INT (6): Yes, definitely yeah. The point of saying cultural humility entails a long-term commitment yeah that's good like there should be a long term, it should be. Again, it should be in everything we do you know, where it's appropriate that should be brought in. So I have no problem with that long-term commitment I don't see it as a burden it would actually make your work more interesting.

MF

RES: And challenges do, do you think it might offer challenges for you.

Ma + Concerns

INT (6): I think the challenges are for something I mentioned earlier just addressing the issues without causing offence, these are very sensitive areas and for me there's definitely things that go on that happen in other cultures that we think are wrong. But I you know it's my duty to remind myself well you don't know or I don't know for example if you take say the Taliban culture and the way women are oppressed and it doesn't have to be Taliban to find but everyone jumps in there and says Oh, you know that's terrible and what are they doing and how can they be allowed to do that but I would say to myself well so many of the women in that community are mothers to sons who grew up with these values, so how is that happening and why, if it's so wrong for women, how can women can't help change the next generation of sons. You know, all these kinds of things I have attitudes about it but I'm probably quite ignorant in my attitudes so finding out more about that would be so interesting and informative. But it's challenging work to do and it's challenging to find the time to do it too.

3 Me. + MM.

Appendix H: Categories & Subcategories

Vignette 1 Coding phase 3

Code 1

Curriculum

Code 1a Uncertainty in role/knowledge

Code1b Essential requirments for culture/curriculum

Code 1c Professional Responsibility

Code 1d Embedding Culture & Diversity into Curriculum

Code 1 e Personal Preparation/learning

Code f Team/Dept Responsibility

Code g Aware changing times

Code 2

Personal Responsibility

C2a Personal /limitations/knowledge/skills

C2b Responsibilityin regard to teaching students

C2c Personal cultural awareness & experience

C2d Integrating culture into practice

C2e Awareness of bias/personal beliefs

C2f Expectation of student qualities and culture

C2g Need for Support

C2h Team Responsibilities and dynamic

C2i Personal approaches to practice

Vignette 2 Coding phase 3 example

Code 8

Cultural Care & CH

C8a Personal engagement /knowledge of CH/culture in teaching

C8b Developing cultural awareness in students

C8c Concerns with teaching cultural care

C8d Particular personal approaches to developing cultural awareness in students

C8e Personal values/attributes that influence approaches to culture

Code 7

Personal Responsibility

C7a Student Learning & Facilitator knowledge

C7b Role of Facilitator

C7c Personal approaches to teaching cultural issues

C7d Personal values

C7e Professional Responsibility to teaching cultural issues

C7f Support from peers/experts

C7g Particular concerns

Interview Schedule Coding phase 3 example

- C17(a) Outline of approaches & Teaching Strategies
- C17(b) Learning ~ Educator & Student
- C17(c) Use of a framework
- C17(d) Necessary skills required
- C17(e) Knowledge & Practice of Cultural Humility
- C17(f) Personal attributes & Values
- C17(h) Curriculum/Discourses
- C17(i) Need for education & Training
- C17(J) Space & Time to reflect
- C17(K) Professionalism & Responsibility
- C17(L) Bias & Assumptions
- C17 (M) Reflection/Life Long Learning
- C17(N) Team Responsibilities
- C17(O) Student Supports
- C17(P) Individualised Care/Holistic Care/Inclusiveness
- C17(Q) Role of the Department/College

Appendix I: Consent Form

College of Social Sciences

Consent Form

Written evidence of consent, through a signed consent form, will not be obtained due to logistical issues relating to the remote interview method. I will share the information sheet and the consent form on Zoom with you prior to the commencement of the interview to ensure you have understood the key principles of participation.

Title of Project: Nurse educators' understanding of cultural humility and their perspectives on its potential to enhance student nurse's delivery of culturally responsive and sensitive care.

Name of Researcher: Ms. Marva Fitzpatrick

Name of Supervisor: Dr. Giovanna Fassetta

- I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
- I acknowledge that participants will be referred to by a pseudonym.
- I acknowledge that there will be no effect on my employment or professional relationships arising from my participation or non-participation in this research.
- I acknowledge that due to the possibility of COVID-19 restrictions written evidence of consent, through a signed consent form, will not be obtained due to logistical issues relating to the remote interview method. Instead, the consent form will be shared over Zoom and verbal consent will be recorded at the start of the interview following inspection of the participant information sheet.
- I understand that the data collected from the interviews will be treated as confidential and kept in secure storage at all times.

- I understand that the researcher will destroy the data collected from the interviews, once the project is complete.
- I agree to waive my copyright to any data collected as part of this project.
- I understand that the primary supervisor will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.
- I acknowledge that copies of transcripts will be returned to participants for verification.
- I give my verbal consent / do not verbally consent to participation in the interview and to being audio-recorded.

Agree

Disagree

Signature of Participant: …………………………. Date…….

Name of Researcher ……………………

Signature ………………………………………

Date ………………………

Appendix J: Ethics Form

7a. College Research Ethics Committee for Non-Clinical Research involving Human Participants/Data

7b.

7c. Staff and Postgraduate Research Students: Application Form for ethical approval

Before completing this form, refer to the guidance notes available at College ethics information and Ethics Information for Applicants.

Completed, typed forms (with supporting documents) should be submitted electronically via the Research Ethics System.

Submit applications **at least 6 weeks in advance** of the intended data collection start date, allowing time for applications to be reviewed, and any recommended amendments to be made.

Applications requiring PVG Clearance/permissions to access participants will not be approved until evidence of this is received by Ethics Administrator. Guidance is available at PVG Guidance.

7d. Applicant Details

Staff Research Project ☐ **Postgraduate Research Project** ☒

Name of Applicant Marva Fitzpatrick

Student ID/Staff Number

School & Subject (Cluster/RKT group) Education

PGR Programme Title (Where applicable) EdD

7e. Application Details

7f.

Project Title Nurse educators' understanding of cultural humility and their perspectives on its potential to enhance student nurse's delivery of culturally responsive and sensitive care.

Data Collection Start Date At least 6 weeks after application submission 01/03/2022

Proposed Project End Date e.g. date of PhD award, article submission, end of funding 31/01/2024

Is this application being submitted to another ethics committee, or has it been previously submitted to another ethics committee? **Yes** ☐ **No** ☒

If Yes provide details Ethical approval is currently being sought from the Technological University of the Shannon Midwest (TUS).

Is the research subject to external funding? (i.e. a sponsor or funding body) **Yes** ☐ **No** ☒

If Yes provide details Enter text here

Does the research involve using networked or electronic data such as internet platforms, apps, social media, secondary data, Big Data? **Yes** ☐ **No** ☒

If YES you must complete and submit the 'Protocol for research dealing with non-standard human data' This can be downloaded from the College ethics website.

1 Description of project Give a brief description of the project.

The project will entail an empirical investigation grounded in the interpretivist/constructivist paradigm (Guba and Lincoln, 1994). Its primary objective is to scrutinize the current teaching practices of nurse educators concerning cultural diversity within nurse education. Additionally, the study aims to explore how integrating fundamental elements of 'cultural humility' across intrapersonal, interpersonal, and systemic levels in their teaching approaches could contribute to fostering students who recognize patients' cultures as dynamic entities crucial to the planning of patient care. The concept of cultural humility was first put forward by Tervalon and Murray-Garcia

(1998) in their seminal work in medicine, describing it as process of 'committing to an ongoing relationship with patients, communities, and colleagues' that requires 'humility as individuals continually engage in self-reflection and self-critique' (p.118). The concept was seen to be distinct from cultural competence which was considered limited in its view that an individual can never reach competent or proficient levels, in every individual culture (Fisher-Borne, Cain, & Martin, 2015, Hook, 2014). Chang et al. (2012) further describes the concept of cultural humility in which the elements of self-questioning, immersion into another person's point of view, active listening, and flexibility that will serve to confront and address unconscious biases or assumptions that a health professional may hold. Cultural humility is important to nurse education as the nursing profession requires successful collaboration between and integration of individuals within the community and hospital settings (Ross, 2010). This project explores the ways in which nurse educators understand cultural humility and the ways in which this concept can inform their practice. Through this nurse educators can improve attitudes that foster understanding of other cultures which is an essential attribute for healthcare providers working with increasingly multicultural and diverse patient populations.

Participants will consist of 10 educators from a nursing program in the Republic of Ireland, each with a minimum of one year of experience in their current role. This requirement ensures that they possess the necessary knowledge regarding the importance of preparing students to provide care for diverse patient populations in their practice. They will be asked to read and respond to two vignettes which are designed to uncover their understandings of cultural humility, from a personal and professional perspective. Semi- structured individual interviews will then be conducted on 10 nurse educators following their reading of the vignettes which will last no longer than 45-60 minutes and will be conducted online via zoom. The interviews will explore the current knowledge and practices relating to cultural care, understandings of cultural humility, understandings of the key principles of cultural humility as it pertains to their practice and how it may enhance or transform their practice. The interviews will be analysed using reflective thematic analysis to capture the underlying values and beliefs and assumptions of the participants within their practice which lends itself to understanding people's experiences, and their views and perceptions (Braun and Clarke, 2006, 2019).

References

Chang E, Simon M, Dong X. (2012). Integrating cultural humility into health care professional education and training. Advanced Health Science Education, 17: 26978.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology' in *Qualitative Research in Psychology*, vol. 3, pp.77-101. Available at: https://www-tandfonline-com.ezproxy.lib.gla.ac.uk/doi/abs/10.1191/1478088706qp063oa

Braun, V. and Clarke, V. (2019) 'Thematic analysis: a reflexive approach' Available at: https://www.psych.auckland.ac.nz/en/about/thematic-analysis.html.

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Cultural humility as an alternative to cultural competence. *Social Work Education*, 34(2), pp. 165–181.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Sage Publications, Inc.

Hook, J. N. (2014). Engaging clients with cultural humility. *Journal of Psychology and Christianity*, 33(3), pp. 277–280.

Ross, L. (2010). Notes from the Field. Learning cultural humility through critical incidents and central challenges in community-based participatory research. Journal of Community Practice, (18), 315-335.

Tervalon M, Murray-Garcia J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved,* 9(2), p.g. 117–125.

PGR Applications – **Supervisors** must complete and sign this section, approving submission for ethical review.

Staff Applications – **Applicant** must complete and sign this section, confirming submission for ethical review.

2 Ethical Risks Comment on any potential research ethics risks involved in the project, and any steps taken to mitigate these risks. Risk Guidance Document is available at Ethics Forms

According to the University of Glasgow Information Risk Classifications, this research carries high risk as it investigates sensitive cultural understandings. As a consequence, the researcher will gain ethical approval both from the University of Glasgow and from the Technological University of the Shannon: Midlands and Midwest (TUS), Athlone (Republic of Ireland) where the participants and the researcher work. The participants will be asked to discuss sensitive topics on

their practice, beliefs, and values in relation to cultural diversity, and this carries the risk of creating discomfort for the participants, who may feel challenged both as people and professionals. This will be addressed by clearly outlining the research questions and the themes and questions to be covered in the vignettes and the interviews prior to the data collection. Moreover, the researcher will assure participants that they may withdraw from the research at any stage, including in advance of the data collection phase and that they will not have to motivate their decision to withdraw.

Should, despite all efforts, feelings of discomfort or insecurity arise during the vignette reading/interviews, participants will be offered the opportunity to stop for as long as they feel necessary. In this case, the interview will be paused, and the participant will be asked if they wish to continue, change the subject, or conclude the interview altogether. Participants who become distressed will be offered advice about where to seek help from the employee advice service at the TUS, which offers free counselling to all members of staff. This information will also be available in the Participant Information Sheet.

The researcher fully understands the need to be aware of and to avoid additional stress for the participants, in particular as she knows that they are dealing with very demanding timetables and busy workloads, during the uncertain times created by the Covid-19 pandemic. The researcher will address this by giving a month's notice via email before the interviews, to give participants plenty of time to organize themselves, read the vignettes, reflect on their responses and ask any questions/doubts they may have. The researcher has scheduled the semi-structured interviews between March 2022 and June 2022, well in advance of the summer holiday period, in order not to put demands on participants when they are not at work. This wide window also offers the participants the opportunity to choose the dates/times that best suit them as well as flexibility to respond to changing circumstances. The researcher will emphasize that participation in the study is entirely voluntary and that consent is given on an ongoing basis.

The researcher works with the participants (albeit not in a position of authority), and she knows that particular care is required when carrying out insider researcher, as it can affect working relationships and may be open to manipulation. She will address this by giving clear information to the participants at all times, allowing participants authority over the information and the data collection (e.g., to object to the vignettes; refuse to answer a question; ask clarification on the motives for the researcher's questions; etc.) and will let them know they can discuss with her any specific concerns on the research process they may have. She will also keep a researcher's log to record any interpersonal issues that may arise and as a way to reflect on the process throughout the fieldwork.

X Enter Signature or GUID Gf71h

X 29/11/2021

3 Names of Researchers/Supervisors

3.1 All Researchers including research assistants and transcribers where appropriate

Title	First and Surname	Telephone	Email (usually UofG)
DR	GIOVANNA FASSETTA	0141 3302431	Giovanna.Fassetta@glasgow.ac.uk
DR	Fiona Patrick	0141 330 4429	Fiona.Patrick@glasgow.ac.uk

3.2 All Supervisors *Principal Supervisor first where applicable*

4 Justification for the research

Why is this research **significant** to the wider community? What might be the **impact** on your practice or on the practice of others? How will the *possible **benefits** to researchers, participants, and others, realised from the project justify any risks or discomfort involved?*

According to the 2016 census, 535,475 non-Irish nationals were residing in Ireland at that time. Although this represents a 1.6 percent decrease compared to the 2011 figure of 544,357, the decline is partially attributed to the rise in individuals with dual Irish nationality, who are categorized as Irish in the census (Central Statistics Office, 2016). The concept of cultural humility has gained momentum among healthcare professionals, including nurse educators, in addressing the deficiencies in meeting the individual cultural needs in healthcare. Cultural humility emphasizes recognizing one's implicit biases, fostering self-awareness, and developing interpersonal sensitivity to appreciate the diverse facets of each individual (culture, gender, sexual identity, race and ethnicity, religion, lifestyle, etc.), thereby promoting patient-centred approaches to nursing care plans. Embracing cultural humility in healthcare provision can ensure that patient-centred care is more respectful and responsive to the unique preferences, needs, and values of each individual, guiding all clinical decisions.

I believe it is now timely for nurse educators to explore ways to enhance their approaches in preparing future nurses in Ireland to deliver safe, unbiased, patient-centred care to the growing and

diverse populations. This entails moving beyond the mastery of skills inherent in competency-based models (Isaacson, 2014) to embracing the practice of self-reflection advocated by the cultural humility approach. This study will prompt nurse educators to examine their understanding of how cultural humility can aid them in recognizing and guiding students to address power dynamics and healthcare inequities inherent in the healthcare system, as well as to demonstrate sensitivity to the impact of power imbalances on culturally and diverse patients. It will also provide them with an opportunity to reflect on strategies that can be integrated into their teaching practices to design nursing curricula that better equip future nurses to deliver culturally competent care to their diverse patient populations. Moreover, the study will benefit patient groups by allowing healthcare practitioners to gain a deeper understanding of their patients and acknowledge the unique aspects of each individual's identity, thereby enabling a more holistic approach to patient care.

References:

Central Statistics Office (CSO), "Census 2016 published reports", available at

Isaacson, M. (2014). Clarifying concepts: cultural humility or competency. Journal of Professional Nursing, 30(3), 251-258. doi: 10.1016/j.profnurs.2013.09.011. PMID: 24939335.

5 Research Methodology and Data Collection

Method	Selected
5.1a Face to face or telephone interview	☐
5.1b Online interview, for example using Teams or Zoom	☒
5.1c Focus group	☐
5.1d Questionnaire	☐
5.1e Online questionnaire Provide indicative *electronic copy with application pending online version*	☐
5.1f Participant observation *Provide an observation proforma*	☐

5.1g **Audio or video-recording interviewees, focus groups or events** Provide evidence of p*ermission* on the consent form. Details should be provided, either in theme/question information or separately.	☒
5.1h Other methodology	☒
If **Other** selected above, provide details here: Participants will be asked to read two vignettes and to reflect on their content prior to the interview. They will also be sent a number of questions relating to each vignette that will test their responses prior to the semi-structured interviews. These questions will be posed to them at the onset of the semi-structured interview. As an insider researcher, I will also keep a personal reflective journal through the data collection and analysis phase of the research.	

5.1 Method of data collection You are **required to provide** *indicative themes/questions in separate documents, in sufficient detail to present a clear view of the project and its ethical implications.*

5.2 Research Methods

Explain the reasons for the chosen method/s, the estimated time commitment required of participants and how the data will be analysed. Include reference to methods of providing confidentiality as indicated below.

Data Collection Methods

The data collection methods were chosen as they are best adapted to the interpretive/constructivist paradigm that underpins this research. Approaches to the collection of data will use three methods (1) reading and reflecting on two vignettes prior to the interview phase and (2) semi-structured interviews and (3) the researchers own personal reflections using a journal.

For the study, the two vignettes will be presented as narrative text and designed to reflect life situations that will resonate with the participant. This has particular relevance to me as a researcher who wants to provide a space for reflection appropriate for studying the deeper issues relevant to the phenomena while reducing participant discomfort (Spalding & Phillips, 2007). Vignettes as a method of data collection are noted for their usefulness in helping participants to articulate embedded beliefs or opinions on subject that may cause difficulty for them to articulate (Boddy,

2005: Denzin & Lincoln, 2018). Vignettes are also an appropriate choice for exploring individuals' experiences and motivations in social and educational settings (Witz *et al.* 2001). As a projective technique the vignette will prompt respondents to discuss a situation without the need for direct personal questioning (Catterall and Ibbotson, 2000). The vignette will be given to participants a week in advance of a follow up semi-structured interview to allow adequate time and space to reflect on their experiences.

The semi-structured interview provides the opportunities for participants to cover the breadth of the research topic, to give detailed answers and to explore new meanings (Gill, Steward, Treasure & Chadwick,2008). Semi-structured interviews also allow the researcher to prepare topics and questions for data collection while affording them the control to change the wording or order of questioning (LaForest, 2009). Others see this method as beneficial when significant information is raised unpredictably in the course of the interview, allowing for detection and expansion of new data (Gill et al., 2008). The interviews will take around 45- 60 minutes. If the participant wishes to continue past the 45- 60 minutes the interview will only continue following the participants' permission. The interviews will take place in an eight-week window, with interviews organised in the first week, so there are other opportunities should the interview need to be postponed. I intend to use open ended questions grounded in the themes of the research and the vignette. I will also introduce follow up questions to build upon possible responses that lack detail. The interviews will be recorded on the University of Glasgow Zoom client server and downloaded to my personal laptop that is password encrypted.

Taking into consideration my personal acquaintance with the participants, transcription will be accompanied by a researcher journal to identify researcher position and decisions taken, to ensure sensitivity to the context and to promote reflexivity (Lapadat 2000). As an insider researcher I will remain aware of the element of reciprocity that may occur and I will endeavour to promote reflexivity throughout. I feel that by keeping a personal record of the research process it will allow me to engage in the opportunity to learn from the research process (Thorpe, 2010) and help me to make key decisions and better remember the sequence of events in the study. This journal can also become a vital source of data as a participant interview in the writing up phase of the study. It will also provide a means for me as a researcher to perform a running check on my own possible biases that I may have carried into the research process (Lincoln and Guba, 1984).

Analysis of the Data

The interviews will be transcribed verbatim and I will ensure credibility of the data by sharing the transcripts with the participants to check for authenticity and give participants the opportunity to change/delete any response they are not comfortable with. Transcriptions will be analysed using

an inductive reflexive thematic analysis in six stages, as described by Braun and Clarke (2019). These steps include: 1) data familiarisation and writing familiarisation notes; 2) systematic data coding; 3) generating initial themes from coded and collated data; 4) developing and reviewing themes; 5) refining, defining and naming themes; and 6) writing the report (Braun and Clarke (2020: 4). Throughout, I will remain committed to the analytical process through "immersion, wondering, writing, retreating and returning to the data" Braun and Clarke (2020: 5) in order to reflect on my own opinions, experiences and thinking and to "look for instances of similar or contrary language and experiences in the data" (Braun and Clarke, 2020: 5). I intend to code the data and determine and organize potential themes using QRS NVivo 10 software in addition to RTA.

References

Boddy, C. (2005). Projective techniques in market research: Valueless subjectivity or insightful reality. International, *Journal of Market Research*, 47, 239–254.

Braun, V. and Clarke, V. (2019) Reflecting on reflexive thematic analysis, *Qualitative Research in Sport, Exercise and Health,* 11(4), pp.589-597.

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Spalding, N J. & Phillips, T (2007). Exploring the use of vignettes: From validity to trustworthiness. *Qualitative Health Research*, 17(7), 954-962.

Thorpe, K. (2010) Reflective learning journals: From concept to practice Reflective Practice. *International and multidisciplinary perspectives,* 5(3), pp 327-343

Witz, K. G., Goodwin, D. R, Hart, R. S. and Thomas, H. S. (2001) An Essentialist Methodology in Education-Related Research using In-depth Interviews, Journal of Curriculum Studies, 33(2), 195-227.

6 Confidentiality and Data Handling

6.1 Will the research involve: (Click to right of ***Select method*** *at top of column to indicate method and* ***select all that apply***

	INTERVIEW	OTHER
Degree of Anonymity		
6.1a De-identified samples or data (i.e. a **reversible** process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location?	☒	☐
6.1b Anonymised samples or data (i.e. an **irreversible** process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates)?	☐	☐
6.1c Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are part of a random sample and are required to return responses with no form of personal identification)?	☐	☐
Use of Names		
6.1d Subject being referred to by pseudonym in any publication arising from the research?	☒	☐
6.1e Participants consent to being named?	☐	☐

6.1g Participants being made aware that **confidentiality may be impossible to guarantee;** for example, in the event of **disclosure of harm or danger** to participants or others	☒	☐
6.1h Participants being made aware that **confidentiality may be impossible to guarantee;** for example, due to **size of sample, particular locations** etc.?	☒	☐
6.1i **Participants being made aware that data may be shared/archived or re-used** in accordance with Data Sharing Guidance provided on Participant Information Sheet?	☐	☐
6.1f Any other methods of protecting the privacy of participants? (e.g. use of direct quotes with specific, written permission only; use of real name with specific, written permission only):	☒	☐

6.2 The following methods of assuring confidentiality of data will be implemented:

6.2a Data will be stored at University of Glasgow * **Paper** (kept secure in locked facility/cabinet) * **Electronic** (files to be available by password only **and** data encrypted; see UofG/IT/InformationSecurity/ConfidentialData for guidance)	 ☐ ☒
6.2b Data will be stored at another site provide details/address below * **Paper** (kept secure in locked facility/cabinet) * **Electronic** (files to be available by password only **and** data encrypted; see UofG/IT/InformationSecurity/ConfidentialData for guidance) **(Provide details/address below)** In a locked cabinet in the researcher's office in the Technological University of Shannon, Athlone Ireland and also on icloud storage on the University of Glasgow one drive	 ☒ ☒

6.2c Other (other methods of securing confidentiality of data in transmission, access and storage) (e.g. data to be encrypted for transmission/security measures if data sent outside UK; cloud storage and access) See UofG Data management support and link given above.	☒
If you have selected **Other** above provide details here: The interviews will be conducted online using the University of Glasgow Zoom Platform via the University of Glasgow log in.	

7 Access to data

7.1 Will anyone other than those named above (researchers, supervisors, examiners, research assistants, Heads of Department, transcribers) **access the research data?** **Yes** ☐

No ☒

If YES please provide details below. If e.g. transcribers or research assistants are not known at this time, please forward details to Ethics Administrator when available.

Enter text here

7.2 Retention and disposal of PERSONAL data

Explain/justify your proposals for retention and disposal of any PERSONAL data to be collected. The definition of personal data is available at UofG GDPR Changes. Further information on GDPR is available at UofG GDPR Guidance)

I will attempt to collect as little personal data as possible and only that which is required for the study. All essential personal data collected (e.g. contact details) will be stored on a password protected laptop. I intend to destroy any personal data, or directly identifiable personal data once de-identification has been completed.

7.3 Retention and disposal of RESEARCH DATA

Explain/justify your proposals for retention and disposal of RESEARCH data to be collected. PGR/Staff research data is expected to be retained for 10 years. Further guidance is available in Code of Good Practice in Research. For Data Management Support, visit Data Management

Audio video recording will be retained on University of Glasgow Zoom Client until downloaded and encrypted by myself. The data will then be deleted. Paper notes and printouts that are used through the transcription and analysis stages will be shredded and placed in confidential waste by January 2023, by myself. All other data (including transcription of interviews) will be stored on the University of Glasgow One Drive and transferred to the Enlighten: Research Data storage. This data will be retained and disposed of in line with University protocols after 10 years.

8 Dissemination of results: (select all that apply)

Method	To Participants	To Peers/Colleagues
8.1a Dissertation	☐	☐
8.1b Thesis (e.g. PhD)	☐	☒
8.1c Journal Articles	☐	☒
8.1d Conference Papers	☐	☒
8.1e Written summary of results to all if requested	☒	☐
8.1f Other or none of the above	☐	☐
If you have selected **Other** above provide details here: Enter text here		

9 Datasets suitable for future re-use will be:

9.1a Openly available via data repository (UKDA, Enlighten, Research Data)	☐
9.1b Available via a data repository but with restricted access	☐
9.1c Available from researchers by personal request	☒
9.1d None of the data will be suitable for future access/reuse	☐
9.1e Other or none of the above	☐
If you have selected **Other** above provide details here: None of the Above	

10 Participants

10.1 How do you intend to recruit participants? Provide as much detail as you can, including what age/type of group will be used for each research activity involved, e.g. interviews

I have access to a cohort of nurse educators in my research area in the Technological University of the Shannon: Midlands Midwest (TUS), Athlone Ireland. I have access to the work email addresses of all participants. I will be seeking permission to access and use these email addresses from the participants and I will then recruit the participants initially through email, with a follow up 'phone call if required. The participants will be known to me through working collaboratively in our professional organisation of work but none will be in a dependent relationship with me.

I will send 10-11 nurse educators the two vignettes a week in advance of their semi-structured interview. I will invite the participants to take part in individual 45-60-minute interviews via email and phone.

10.2 Target Participant Group Guidance on the age of legal capacity available on Age of Legal Capacity (Scotland) and also Principles of Consent (England, Wales and Northern Ireland)

Select all that apply

10.2a Students * or Staff of the University of Glasgow (* See Working with Glasgow University Students)	☐
10.2b Adults (over 18 years old **and competent** to give consent)	☒
10.2c Adults (over 18 years old who **may not** be competent to give consent)	☐
10.2d Young people ages 16-17 years old	☐
10.2e Children under 16 years old	☐

10.3 Will financial inducements/incentives, other than reasonable expenses and compensation for time, be offered to participants? **Yes** ☐ **No** ☒

If YES provide details

Enter text here

10.4 Number of participants G*ive details of different age groups/activities involved* ***for each method of data collection***

The aim will be to interview 11- 12 nurse educators, using Zoom, who have been teaching on an undergraduate nursing programme for at least 2 yrs

10.5 Are any of the participants in a dependent relationship with any of the investigators, particularly those involved in recruiting for or conducting the project? i.e. student/teacher, employee/employer, patient/doctor, student/supervisor etc.

Yes ☐ **No** ☒

If YES provide details

Enter text here

11a University of Glasgow	☐
11b Outside location/s provide details/address below Technological University of the Shannon: Midlands Midwest, Athlone Ireland	☒

12 Permissions to access participants

12.1 Do you require permission to gain access to research participants within an organisation? e.g. Academic institution, **including University of Glasgow**, Private Company; school; Local Authority; Voluntary Organisation; Overseas institution.

Yes ☒ **No** ☐

12.2 If YES

is evidence of this permission provided with this application? Yes ☐ **No** ☒

NB: S*eparate permission to survey students must be obtained, usually from the appropriate authority, prior to any such survey being undertaken once ethical approval has been granted. Once obtained, proof of permission must be forwarded to the Ethics Administrator. More details available on* Information for Applicants. See Working with Glasgow University Students

12.3 If applicable, list the University of Glasgow students that you intend to contact e.g. 30 students from X course. Information for Applicants has guidance.

Enter text here

12.4 If NO

to either of the above questions, explain why permission is NOT required, or why evidence is not provided with this application:

Permission from the Ethics Committee in the Technological University of the Shannon, Athlone Ireland will be sought also. A copy of their ethical approval will be sent as soon as it has been granted.

13 Informed Consent Consult the guidance on Ethics Forms page to understand what you are required to provide in the Participant Information Sheet (a written 'plain language' statement that explains your project and invites participation)

Participant Information	YES	NO
13a Have you attached your Participant Information Sheet?	☒	☐
13b Will a copy of the Participant Information Sheet be offered to participants to keep?	☒	☐
If NO to 13a or 13b above, please give details here: Enter text here		
13c Are any participants likely to require special consideration in the preparation of the Participant Information Sheet, to ensure informed consent? e.g. use of child friendly language or English as a second language	☐	☒
If YES to 13c above, please give details here: Enter text here		

14 How will informed consent by individual participants or guardians be evidenced? Written evidence of informed consent is normally obtained and retained using a formal consent form, with copies provided for review

select all that apply

Participant Consent	
14a Signed consent form	☒
14b Recorded verbal consent	☐
14c Confirmed by return of survey (evidence of clear agreement of consent to use participant data must be provided at start of survey e.g. by use of tick box)	☐
14d Other	☐
If you have selected Other above provide details here: Enter text here	

15 Justification, if **written** evidence of informed consent will **NOT** be obtained and retained:

Written evidence of consent, through a signed consent form, will be obtained electronically from the participants in advance of the interview. I will send the consent form to them at least two weeks in advance of the interview and ask for them to return prior to the allotted interview time. I will not conduct the interview until I have received this signed consent form from each participant.

16 Monitoring

16. How will the project be monitored to ensure that the research is being carried out as approved *e.g. give details of regular meetings/skype/email contact.*

Regular contact will be made with supervisor either by email, zoom or through phone calls. This will be through monthly meetings or as required should any concern arise.

17 Health and Safety/Risk

17. Will the project have any personal safety implications for you, and/or all other researchers and participants involved in the research? (This should include risks associated with COVID-19 but **other** than lone fieldwork – refer to Section 18 for this)

Yes ☐ **No** ☒

If **YES,** please explain the potential issues and how you intend to manage them:

Enter text here

18 Risk

18.1 Does the activity Involve Lone Field Work, lone working or travel to unfamiliar places?

See Information for Applicants, Lone Working **Yes** ☐ **no** ☒

If YES, please explain

Enter text here

18.2 Does this research include any sensitive topics or vulnerable groups? Risk guidance is available at Ethics Forms

_**Yes** ☒ **no** ☐

If YES, please explain the reason for including these and how the sensitivity will be managed

I will take ample time to explain the study thoroughly in the participant information sheet and discuss their role with them via email or a phone call if necessary before inviting them to participate. Throughout the research process, my foremost principle will be to do no harm to the participants and to minimize any potential distress during the interview process or while reading and reviewing the vignettes. I will continuously engage with all participants to explore ways to mitigate any stressful effects of the interview or vignette reading, especially given the online format. Additionally, discussing sensitive information related to their practice, beliefs, and values concerning diverse cultures may cause discomfort to the participants. Therefore, I will address this by clearly outlining the research questions and the themes and questions to be covered in the vignettes and interviews.

Moreover, participants will be assured of their right to withdraw from the research at any stage, including before the data collection phase, without providing any reason. If feelings of discomfort or insecurity arise during the vignette reading or interviews, participants will have the opportunity to pause, change the subject, or withdraw from the interview. If such situations arise during the interview, it will be paused, and participants will be given the option to continue, change the subject, or stop the interview altogether. Prior to data collection, participants will be informed about the employee assistance program at Technological University of the Shannon, which offers free counselling facilities for staff members who may become distressed as a result of their participation.

Given my existing relationship with the participants, I will exercise particular caution as an insider researcher to prevent any potential abuse. Participants will have some authority over the information and data collection process, and they will have access to discuss any concerns they may have with me. Transcription will be accompanied by the use of a researcher log to document my position and decisions and to ensure sensitivity to the context and promote reflexivity. Transcribed transcripts will be shared with all participants to allow them to amend or remove any text they are uncomfortable with.

Throughout the data collection and analysis phases, I will promote reflexivity by keeping a reflective journal to strengthen the trustworthiness of the study. Reflexivity is essential for ensuring the trustworthiness of qualitative research, as it involves recognizing how the researcher and the subjective elements of the study can influence and shape the research process (Finlay & Gough, 2003).

18.3 How will you ensure that you minimise any possible **distress** caused to any **participants** by the research process? Consider potential disruption or negative consequences that could cause emotional, social or economic distress.

If on the date that has been agreed the participant has an unexpected deadline or change in circumstance, the interview can be re-arranged. The interviews will take place in an 8-week window, with interviews organised from the first week, so there are other opportunities should the interview need to be postponed. The interviews will be taking place by Zoom, and I am aware that the participants will be 'inviting' me into their home or their office. If the participants are not comfortable with this, they will be able to switch to audio feed only or select a background from Zoom to use. I will be conducting the interviews and transcribing in my own home, where I live by myself, so there will be no opportunity for the content of the interview to be overheard. Due to the possibility of the ongoing COVID-19 pandemic participants may be struggling with complex situations in their personal life or with the uncertainty surrounding the procedures relating to possible local lockdowns and return to remote teaching. Scheduled interviews will be postponed if there is an unexpected change in working practices for that week to ensure that the participants can adjust to those changes without any additional pressure. The project timescale has been planned so that nurse educators will have had time to adjust to current Covid- 19 protocols. The aim will be to have interviews completed before June 2022, to avoid any disruption to theory holiday period. The interview will be scheduled with the participants at a time that suits them to avoid the run up to the examination period and account for any changes to the exam schedule or exam boards that may occur.

18.4 What procedures are in place for the appropriate referral of a study **participant** who discloses an **emotional, psychological, health, education**, or **other issue** during the course of the research or is identified by the researcher to have such a need?

If issues relating to the difficulties of the COVID-19 situation or issues relating to cultural values and beliefs are raised, I will respond to these with sensitivity, as I am also nurse educator working in the same environment as the participant who has similar concerns in relation to cultural care in the work environment and has also experienced the implications of post lockdown teaching. Advice will be offered about where to seek areas of support e.g. participant development lead of their programme, union advice lines or the Employee Assistance Service which provides free counselling through their College on request (information will be taken to the interviews and presented in the participant information sheet.)

18.5 Does this project require Protection of Vulnerable Groups (PVG) clearance? Guidance available at UofG Protection of Vulnerable Groups and additionally at: MyGov Types of Disclosure)

Yes ☐ **no** ☒

If YES please provide confirmation of certification held or being sought

Enter text here

19 Please provide additional details if the proposed research involves:

- Work involving the use of research participants outside GB, NI, the Channel Islands, or the Isle of Man
- The use of hazardous materials
- Non CE marked medical devices
- Molecules or compounds developed and manufactured at the UofG
- Number of participants in excess of 5000
- Work involving research participants known to be pregnant at the time of the project

Activity involving any of the above may require additional insurance cover to be put in place

See Insurance Guidance

Please contact debra.stuart@glasgow.ac.uk for further information regarding additional insurance requirements

If applicable, please provide details

Enter text here

20 Government Legislation further information available at Information for Applicants

20.1 Have you made yourself familiar with the requirements of the following legislation?	YES	NO
General Data Protection Regulation (GDPR) (May 2018)	☒	☐
Freedom of Information (Scotland) Act 2002	☒	☐

20.2 If NO to either of the above questions, explain why the legislation is not relevant.

Enter text here

21 Declaration by Researchers And Supervisors

! Application will be returned if declaration is not signed and dated !

- The information contained herein is, to the best of my knowledge and belief, accurate.
- I have read the University's current human ethics guidelines, and accept responsibility for the conduct of the procedures set out in the attached application in accordance with the guidelines, the University's Code of Conduct for Research and any other condition laid down by the University of Glasgow Ethics Committee and the College of Social Sciences Research Ethics Committee.
- I and my co-researcher/s or supporting staff have the appropriate qualifications, experience, and facilities to conduct the research set out in the attached application and to deal effectively with any emergencies and contingencies related to the research that may arise.
- I understand that **no** research work involving human participants or data collection can commence until I have been granted full ethical approval by the College of Social Sciences Research Ethics Committee.

Applicant/Researcher/s

X Enter Signature or GUID 2423087F

X 29/11/2021

Supervisor/s

(Where Applicant Is Student)

X Enter Signature or GUID Gf71h

X 29/11/2021

For Supervisors – Please note that by submitting this application the supervisor confirms that:

- The student is aware of the College ethics requirements.
- The topic merits further research.

- The student has the relevant skills to begin research.
- If interviewing, the student has produced an appropriate information sheet for participants.
- The procedures for recruitment and obtaining informed consent are appropriate.

End Of Application Form.

Applications should be submitted electronically as follows:

Upload the completed form, along with any other required documents by logging in to the Research Ethics System at: https://frontdoor.spa.gla.ac.uk/login/

NB: PGR students are required to upload their application which is then forwarded to their named supervisor for approval and submission to the College Research Ethics Committee.