NURSES' MULTICULTURAL TRANSACTIONS WITH CRITICALLY ILL PATIENTS' KINS AND ITS' IMPACT ON QUALITY OF CARE:

A STUDY AT KENYATTA NATIONAL HOSPITAL CRITICAL CARE UNIT

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DECLARATION

I, Ndirangu . J. Wambui declare that this research dissertation titled Nurses Multicultural Transactions with Critically ill Patient's Kin and its impact on Quality of Care is my original work and has not been submitted to any other institution by any person for academic grades.

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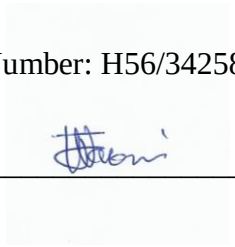
Signature:  Date*:* 29/11/2021

DEDICATION

I dedicate this dissertation to my lovely family and friends for their prayers and unending support. You have inspired and encouraged me all the way.

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First, I want to thank The Almighty God for his strength and enabling me get this far.

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SUPERVISORS' CERTIFICATE OF APPROVAL

We the undersigned certify that this dissertation has been submitted for the award of a Masters Degree in Nursing Sciences (Critical Care) of the University of Nairobi with our approval as the internal supervisors.

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LIST OF ABBREVIATIONS AND ACRONYMS

BScN- Bachelor of Science in Nursing

CCU- Critical Care Unit

CCN- Critical Care Nurse

CME – Continuous medical education

ERC – Ethics review committee

JSTOR – Journal storage

KNH- Kenyatta National Hospital

MScN- Masters of Science in Nursing

PPU- Pediatric Palliative Unit

UoN – University of Nairobi

OPERATIONAL DEFINITIONS

Critical Care Unit- A special unit in a hospital that attends to very critically ill patients with risk of organ failure or support of failed body organs.

Critical Care Nurse- A nurse who is specially trained to nurse a critically ill patient and use of special devices / machines to assist and support organ functions.

Critically ill Patient - Patient with life threatening conditions that require specialized care and monitoring with assistance of life saving devices/ machines in Critical Care Unit (CCU).

Culture - Customs, beliefs, values, symbols, and social behaviors and a particular way of life in a group of people passed from one generation to the other.

Cultural Competence - Knowledge and understanding of the social cultural, traditional and faith beliefs of different cultural groups of people and being able to incorporate them in the care of an individual patient if they will make a positive impact into their health.

Euthanasia - Merciful termination of life of a critically ill patient to ease suffering.

Multicultural Kins – Refers to persons related or close to a critically ill patient who is admitted in CCU. This person speaks or communicates and makes decisions on behalf of the critically ill patient who is limited by their critical condition.

Multicultural Transactions – Refers to therapeutic engagement between nurses and persons with close relations to the critically ill patients (kins) for purpose of quality care provision. In the context of this study the patients are not able to communicate due to their critical condition and hence the kins do it on their behalf. These patients' kins come from different cultural backgrounds, and according to Madeleine Leininger (1995), (whose theory informs this study)

clients view health and treatment through their own cultural lens, which impacts their overall health.

Multicultural - Different cultural or ethnic groups each having with their own beliefs and norms. A patient can belong to different cultural orientations (that is a mixture of cultures) due to intermarriages.

Impact on Quality of Care: Negative or positive effects on the care given to the critically ill patient as nurses transact with their multicultural kins that may have an effect on the outcome.

ABSTRACT

Introduction: Patients from different cultural backgrounds are admitted in critical care unit (CCU)**.** Nurses are faced with challenges in trying to incorporate the patient's cultural needs in health care and at the same time render quality care. Most of the patients in CCU are unable to communicate effectively due to their level of consciousness, thus communication is between the nurse and the next of kin. Thus, multicultural transaction in such situations is very important as it enhances delivery of quality care.
Study Objective: To explore the nurses' multicultural transactions with critically ill patient's kins and its' impact on quality of care at KNH CCU.

Methodology: A descriptive phenomenological study design was employed where nurses gave their own lived experiences in multicultural transactions with critically ill patients' kins. Study population was critical care nurses who had worked in CCU based on the inclusion criteria. Purposive sampling method was used. Data was collected through in-depth interviews using an interview guide informed by study objectives. Audio recorded data was transcribed verbatim and entered into a computer through a word processing program and entered into QSR international NVivo 11 Software for analysis. Content analysis technique was used to help identify themes.

Results: Five main themes emerged from the study which are; restrictive cultural beliefs, Nurse personal influence in care, Nurses response in care, limitation of care and enabling practice. In investigating the nurse culture integration in care, some nurses found it difficult to integrate the kins/patients' culture into care but there were those who were able to integrate some of the culture into patients' care. Nurse's cultural competency was found to be low which limited their ability to handle each situation critically and improve patient outcomes. Nurse's personal culture was not found to influence patient care but was mostly guided by the nurse code of ethics. Main challenges included difficulty in management of the cultural/spiritual needs of kins.

Conclusion and Recommendations: From the study it was noted that critical care nurses lacked cultural competency in multicultural transaction. This explains the constant conflicts as observed in the analysis. Training on cultural competency is required to improve interaction with kins and patients in critical care unit. The critical care unit should incorporate a multidisciplinary team that will put into focus the different needs of kins as they seek to improve the quality of care in critical care unit.

CHAPTER ONE: INTRODUCTION

1.1. Background of the Study

Culture is a word or term that refers to concepts of ethnicity, race, and shared identity, and most often based on factors of differentiation such as nationality, religion, language, social class (Gopalkrishnan 2019). According to the National Institutes of Health (NIH) 2021, cultural respect is vital to reduce health disparities and improve access to high-quality healthcare that is responsive to patients' needs. Nurses must respond to changing patient demographics to provide culturally sensitive care. Communication with patients admitted in the critical care units as well as their kins forms the basis of therapeutic interactions with the health care team. The patient's kin play a crucial role because the patient is often not able to communicate their needs comprehensibly (Gopalkrishnan 2019). Gohal and Kherat (2019) argue that the role played by the kins is vital especially in the critical care units.

Naturally, there is heterogeneity in patient populations, originating from several multicultural backgrounds, experiences, and environments. These different patient cultural backgrounds may differ from the predominant cultures where the health facility occupies, bringing a conflict in the therapeutic communication process. The health care providers need to be aware and recognize these diversities by being culturally competent. Cultural competence involves aspects of being mindful, understanding, respectful, and when feasible, accommodating patient cultural norms.

As reported by Kaihlanen, Hietapakka and Heponiemi (2019) the significance of cultural competence is noticeable in the provision of quality healthcare, with more knowledge needed on different educational models and approaches that aim to increase cultural competence. Many times, communication and subsequent health transactions can be hindered by inability to recognize and adapt to the multi-ethnic diversity. According to Brooks, Melissa, Bloomer,

Elizabeth, & Manias (2018), the lack of cultural sensitivity in communication results in missed opportunities for understanding patients and kins needs resulting in their distress. These missed opportunities contribute to health disparities which can contribute to poor health outcomes. Melissa, Douglas, Robin, Rachael, and Steven (2020) assert that despite a health care provider's good intent, deficient cultural understanding can lead to decreased client compliance and poor health outcomes. In an environment of Cultural diversity in a health care system, health professionals experience many challenges with patients from diverse cultural settings. Some of the challenges entail the absence of cultural sensitivity and comprehension, health literacy, and perspectives of anticipated versus perceived care (Hyatt et al., 2017).

1.2 Problem statement

Multiple cultures influence the approach to therapeutic communication, which can affect the quality of care either positively or negatively. In settings where the patient and the caregiver cannot communicate in the same dialect, there may be loss of information. This is especially apparent in CCU where the patient relies on their kin to communicate their needs and wishes effectively to the health care team. Effective communication is believed to occur when people communicate to each other in a language that the communicants understand best (Ayieta, 2020). Accommodation and understanding patient's culture in a multicultural environment help improve nurse- patient relationship, quality of care and increases job satisfaction (Atanga & Ayong, 2017).

Nursing staff are faced with multiple difficulties, and challenges in giving care and treatment that respects the cultural stance of the patient especially when there is communication barrier. Amiri (2016) asserted that communication becomes a significant challenge when medical practitioners

and clients speak different languages. Nurses Multicultural transactions with patients' kins and its impact on quality of care in CCU has not been established.

Some of challenges nurses experience with multicultural kins are religious/faith and traditional beliefs like refusal of blood transfusion to their patient, merciful termination of life (euthanasia) for their patient, body collection from the unit immediately after death for cultural and religious rituals, charms and paraphernalia put on patient's body, non-adherence to visiting hours. Some patients are limited by their culture or religious beliefs to take certain kinds of treatments that are lifesaving. Nurse's experience on delivery of care to multicultural patients is demanding, challenging, and brings tension and barriers, cultural manifestations and ethical responsibilities of care are interfered with (Murcia & Lopez, 2016). The nurse is the closest health care worker who spends a significant amount of time with the patient and inevitably interacts with the kins. These interactions may involve explanations of the care with the expectations that the kin will make the right decisions for the patient. Without cultural competence, dealing with multicultural kins is challenging. The purpose of this study is to explore nurses' transactions with critically ill patients' kins in CCU Kenyatta National Hospital (KNH) and its' impact on quality of care.

1.3 Research Questions

i. How competent are critical care nurses in multicultural transactions with critically ill patients' kins in KNH CCU?

ii. Which specific aspects of multicultural transactions with critically ill patients' kins in KNH CCU do nurses perceive to impact on quality of care?

iii. What challenges do nurse face in multicultural transactions with critically ill patients' kins in KNH CCU**?**

1.4 Study Objectives

1.4.1 Broad Objective

To explore nurses' multicultural transactions with critically ill patients' kins in KNH CCU and its impact on quality of care at KNH CCU

1.4.2 Specific Objectives

I. To describe the specific aspects of multicultural transactions with critically ill patients' kins in KNH CCU that critical care nurses perceive to impact on quality of care.

II. To explore nurses' competence on multicultural transactions with critically ill patients' kins in KNH CCU.

III. To identify the challenges nurses face in multicultural transactions with critically ill patients' kins in KNH CCU.

1.5 Justification of the Study

Culture is an integral part of care. It is essential for every healthcare practitioner to be aware of patients' culture so as to provide holistic care. The interactions with the patients and their kin are important in therapeutic communication. The Brisbane Declaration which was written in 2016, refers to a set of guidelines for CCU nurses concerning patients who are culturally, and ethnically different in terms of their backgrounds. The Declaration can be adopted for medical care and education standards by every CCU nurse, in every hospital unit, and in all medical

institutions regardless of their geographic location, social divisions, or political set-up patients *up* (Ozga et.al., 2018). This study explores the nurse's multicultural transactions with critically ill patients' kins in KNH CCU and its impact on quality of care. The results of the study will aid in formulation of policies that can guide on anticipation and prevention of challenges that are encountered during multicultural transactions and how to deal with these challenges if they present. This will also enhance teamwork in dealing with the challenges that come up positively impact the quality of care.

1.6 Rationale for the Study

This study will add to the body of knowledge and strengthen nursing curriculum, since no such previous studies have been done in KNH CCU. Nurses on the other hand will get an opportunity to be sensitized and trained on cultural competence and avoid stereotyping of communities. It is hoped that the study findings will provide information regarding culture and care of the critically ill that will inform policies, improve practice and add to research literature. The study will also be used as a reference by other researchers in future.

1.7 Study limitations and Delimitations

1.7.1 Limitations

Study findings may not be transferable to other critical care units in the region. These units may not be like KNH CCU which is a National Referral hospital in a cosmopolitan area and hence patients are from diverse back grounds. The other county CCUs may have minimal cultural diversity and the nurses may be well versed with the cultures in that geographical area. Due to COVID 19 pandemic, face to face interviews were not be viable. Internet disruptions during the virtual interviews though minimal were experienced.

1.7.2 Delimitations

The researcher recommended similar studies in other Critical Care Units. In-depth interviews were conducted virtually and trustworthiness was maintained by developing rapport with participants and observing autonomy. Authority was sort from the participant for audio recording the interview. Where there were disruptions, the participants were requested to repeat what was missed out.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This section highlighted literature review from various search engines, PubMed, Google Scholar, HINARI, and JSTOR. Madeline Leininger's theory of transcultural nursing's main focus was for nursing care to fit with or to have beneficial meaning or beneficial health outcomes for people of different or similar cultural backgrounds (Gonza 2021). The theory incorporates several health care facets, and culture. Beer and Chipps (2014) stated that the interest in culture and healthcare started growing in Florence Nightingale's era who talked about transcultural nursing concept in the 19th century while giving advice to British nurses working in India. She recommended patients' cultural background be considered while planning care. Transcultural nursing was later introduced in the 1950s as a formal research area and practice for nurses who were striving to provide ideal and culturally suitable patient care. CCU is a hospital unit where patients receive treatment for life threatening conditions. Families or kins of CCU patients give pertinent information on behalf of the patient. They also share decision making, clearing of the hospital bills, act as a legal representatives and give consent for procedures (Kehali, Berhane & Gize 2020).

2.2 Nurses' Cultural Competence on Multicultural Transactions

2.2.1 Cultural Competence

Cultural competence entails awareness, knowledge, skills and the procedures required by professionals, individuals, organizations, and systems to function properly and efficiently in places that cultures are not similar (Gopalkrishnan 2019). It is one of the principal foundations of clinical nursing that has not yet been clearly defined and analyzed and hence there are many

different views regarding this issue (Sharifi, Adib-Hajbagher, Najafi 2019). The experience by healthcare professional when attending to culturally diverse patients is challenging and frustrating. There is need for nurses to have cultural knowledge, and understanding of patients' cultures. This is a critical facet in the provision of effective and efficient care but most of the time workload and communication barrier does not allow this interaction. The essence of cultural competency is noticeable with regards to healthcare quality. Additional knowledge is required concerning diverse educational models, and approach mechanisms aiming at increasing cultural competence. With regards to the CCU setting, cultural competence is defined as a comprehension of how cultural and social factors impact the health beliefs, and patient behavior. It also entails how the factors are regarded at divergent levels of a healthcare delivery system that assures high quality care provision (Kaihlanen, Hietapakka, & Heponiemi, 2019).

2.2.3 How Nurses Gain Cultural Competence

Cultural competence in nursing is the capability of the nurse to dispense best healthcare and demonstrate awareness of patients' beliefs race and values or having knowledge about the patients' diversity and attending to them with this in mind. Cultural competence is of great importance in the CCU, where kins are particularly emotional due to patient's critical condition. Giving consent to emergency procedures and making decision some of which they don't approve might result in problems. Provision of high-quality health care to culturally diverse patients is realizable if the healthcare team members have some basic cultural competence. Cultural variances unawareness can result in great misunderstandings causing patients' dissatisfaction and medical errors even in nursing procedures (Ozga et al., 2018). For nurses to give care that is aligned to patients' culture, they must be aware about their own culture and that of their profession. They should bear in mind that each individual has their own culture. Nursing culture

includes values such as displaying kindness, showing empathy, being truthful to health prevention and promotion and, and respect of patients choices. The age of nurses, experience, and birth country can impact their perception of Cultural Competence. For a nurse to gain cultural competence, they require to have been exposed to the care of culturally diverse patients from different countries. Proponents of healthcare such as healthcare organizations should provide continuous cultural education programs to enhance the level of cultural competence among the nursing staff to heighten their preparedness in dealing with challenges as a result of cross-cultural interplay (Adlan, Almutairi, & Nasim, 2017). People have a tendency of comparing their cultures with others and are not conversant with those of others. If Cultural competence was included in the nursing curriculum, then students would be able to recognize the patients' culture and individualize care. (Beer, & Chipps, 2014).

2.2.3 Impact of cultural competence on patient care

Nurses are expected to provide safe clinical care and also remain sensitive to the patients' culture. It is very challenging for health professionals to provide culturally competent quality care in a multicultural environment. According to Beer and Chipps (2014) a nurse practitioner who is culturally competent must be able to do an individual patient assessment and not assume their beliefs and health practices. They must be culturally sensitive and develop awareness in utilizing knowledge related to culture gender and sexual orientation. They should be able to factor patients' culture into health care effectively. Family- patient centered care should be incorporated and nurses should adjust their outlook and behaviors to satisfy diverse multicultural patient groups. Cultural competence allows holistic individualized health care. Lack of cultural competence can contribute to poor therapeutic relationship with patients and their kins and may lead to inequality in care provision (Zarzyca et al., 2020). Cultural competence leads to increased

satisfaction and well beings of patients from various cultural backgrounds and contributes to better relations between staff and patient (Tang et al., 2019). One factor that affects the quality of nursing care is cultural competency and one of the criteria to measure that quality is the patient or kin satisfaction (Mafakheril, Anboohi, Borhani, & Kazemi 2020).

2.3 Specific Aspects of Multicultural Transactions and their Impact on Quality of Care

2.3.1 Culture awareness

Critical illness of one member of a family impacts the well-being of every other family member and changes the entire life of the family as a whole. Critical illness frequently happens with no warning and normally patients and their kins have no time to get prepared. If the kin's critical needs in CCU can be attained, desirable outcomes for the patient and the kins at large can be attained. The nurse should be able to identify these needs early enough and accurately in order to help the kins. Many patients in CCU will not be able to communicate because they are either sedated, mechanically ventilated, confused or in coma. There occurs a burden in decision-making and treatment options for the kins and more so when there is language barrier (Chhetri & Thulung 2018). Cultural awareness is a significant challenge to healthcare workers and is an issue that continues to grow in magnitude as people continue to immigrate for various reasons Cultural awareness is also crucial especially in CCU when it comes to personal care for example in bathing a patient, they may not be able to communicate or lack strength
to express their sentiments but are aware of all physical contact (Benbenishty et.al, 2019). Increased cultural awareness helps facilitate healthy communication between healthcare professionals and patients/kins, and this is a crucial component of quality healthcare (Hietapakka & Heponiemi 2019).

2.3.2 Cultural Beliefs

In a study by Kim (2020) among Korean nurses, in their experience with multicultural Muslim patients, the following sentiments were raised by the nurses; it was hard to demonstrate nursing professionalism because traditional care was valued more than nursing care, nurses had low self-esteem caused by work imposed low social status, the people preferred family judgment over medical decision. Nursing care was to be based on religion than medical treatment to follow. Folk remedies and religion during hospitalization were the maintenance treatment. Nurses were supposed to provide gender-sensitive nursing care and plan the medical treatment in accordance to the family man's decisions. Kim (2020) also continued to say that, nursing care was limited due to strict separation of sex and overcoming communication difficulties was mandatory for one to provide high quality nursing care; Arabic language was a major obstacle to providing cultural nursing. Immediate nursing care was done with the help of a medical interpreter. There was limited nursing care due to cultural differences within multicultural medical teams and nurses became frustrated with the different work cultures. All problems were to be resolved in Korean style putting patient care in the center of multicultural medical team, meaning they were to dedicate effort to rapport building with patient of different languages and recognize that patient respect and trust building were the beginning of high-quality care.

According to Almutairi, Adlan, and Nasim (2017), Cultural diversity most of the time results in misunderstandings, clashes, disputes, discrimination, ethnocentrism, and stereotyping because of persistent intersection of several variables like traditional disparities, behaviors, moral and ethical views, cultural perceptions of sickness, and language barriers. Haverinen (2017) recommended how outcomes of intercultural communication can be improved. This was by

educating and creating awareness towards intercultural communication among the nurses. Communication should be more focused and interactive with multicultural kins, Emphasis on family centered care on a daily basis and more support services to intercultural families.

2.3.3 Kins/patients Needs Identification

To overcome language and cultural barriers, CCU ought to be organized and structured in a way that they create a more conducive environment for families and the admitted patients. Substitute communication techniques ought to be available in CCUs and interpreters should also be available. As alluded by Listerfelt, Fridh and Lindahl (2019), healthcare workers need to be educated on cultural competence and the promotion of an intercultural approach.

Madeline Leininger in trying to address cultural challenges in the nursing field initiated and developed the theory of transcultural nursing. This is an area of nursing that centers on patient care, health and environment. Transcultural nursing addresses the cultural needs of the patient, and access to equal treatment, cultural beliefs, respect and practices like religion, diet, personal care needs and daily routines, communication needs and cultural safety needs. Recently Transcultural nursing has been incorporated in nursing profession and is taught in some colleges of nursing to educate students in patient assessment and provision of cultural and competent quality nursing care (Atanga & Ayong, 2017).

Patients who are awake and communicating and have language barrier can benefit by having an interpreter, that functions as a cultural broker or literacy guide when communicating in the CCU setting in which care is specifically compound and proper communication is essential, and decision making becomes a challenge (Nataly et al., 2020). An absence of cultural understanding enhances pessimistic attitudes regarding cross-cultural care, and as well impacts healthcare

practitioners ‘perceived readiness to care for the culturally different patients. Concerns associated with language, and culture is acknowledged as risks to patient safety in hospitals. Effective and efficient communication among health practitioners, patients, and their families is known to be essential drivers for quality care. A significant number of culturally diversified patients experience communication challenges for healthcare delivery, specifically when socio-cultural disparities are not fully accepted, valued, or comprehended.

According to Debesay et al., (2014), unfamiliar cultural expressions norms and values of multicultural patients challenge the normal routines and procedures performed by nurses. They have limited control over patients and sometimes are forced to break away from usual knowledge practices as they care for ethnic minority patients. The nurse expresses insecurity feelings resulting from the inability to foretell patients’ reactions to given situations. They fear causing any offence while performing some procedures like bathing, catheterization and drug administration like rectal suppositories. They also feared crossing the cultural boundaries not knowing how the patient would react when the nurse does cross the boundary or come too close. Diaz and Kumar (2018), asserted that a clear minority of doctor’s regarded that immigrant patients obtained similar quality of care when juxtaposed to Norwegian-born patients.

The Pediatric Palliative Care (PPC) is so important and culturally relevant, but numerous barriers and challenges block the consistent effort to provide this care among the multicultural community. Pediatric health care providers expressed that cultural differences are a frequent barrier to adequate PPC. Disparities are well established in end of life and disease-based care related to race, ethnicity, primary language, and financial resources. PPC providers have recognized the need to recognize and incorporate religious and spiritual support into

pediatric family-centered care, since it impacts medical decision making (Rosenberg et al., 2019).

Critical care nurses (CCN) are patient's advocate and executors of patient care in CCU, a unit which is highly advanced in technology and care. In CCU, patients and their kins find traditional practices giving them some sense of hope and comfort. Planning of individualized care must be planned in harmony with the client's values and beliefs. The objective of the nurse is to plan which care is best for their patients and hence they need to know which cultural differences are likely to cause dispute, and compromise the outcome of their patients. They also ought to familiarize themselves to country specific cultural traditions. During resuscitation attempts, it was noted with a lot of concern that members of the family were left out and yet some of the people have a tight family bond. Conflicts and stress can arise amongst healthcare workers due to cultural unawareness and inability to give culturally competent care to patients and their kin (De Beer, & Chipps 2014).

2.4 Nurses Challenges in Multicultural Transactions

2.4.1 Communication/Linguistic Barriers

In order for communication to be effective, the receiver and the sender of the information must understand each other. This however is not always the case and different cultural barriers can hinder this. According to a study done by Listerfelt, Fridh and Lindahl (2019), interacting with the relatives of culturally diverse patients was reported as challenging due to linguistic and cultural barriers. To overcome linguistic and cultural barriers, critical care unit should be reorganized and restructured in such a way that it creates a more welcoming environment for relatives. Alternative methods of communication should be created and traditional ways of using

support from interpreter re-evaluated. CCN will need education on cultural competence and the promotion of an intercultural approach, which is key. More research programme development was also recommended. According to Alshammari, and Guilhermino (2019), communication barriers are common in many countries health care centers and they adversely affect the overall quality of health services.

People of the South Asian community were noted growing fast demographically in the United States by the Health care workers. Three types of communication challenges encountered by health workers while serving this population were, ensuring effective interpretation, identifying a spokesperson, and challenges of different cultural norms. The challenges were addressed by; inquiring about patients' and families' preferences and early identification of a family spokesperson. Patient stereotyping was to be avoided, early identification of challenges and strategies to address them adopted. This was to help in provision of culturally sensitive person-centered services for critically ill patients and their kins (Listerfelt, Fridh & Lindahl 2019). Health care workers and especially nurses who interact with the patient and their kins mostly are faced with several challenges in the provision of treatment and care aligned to the culture. One major challenge occurring in transcultural interaction is when medical practitioners and clients speak divergent languages (Amiri, Heydari, Nayeri, Vedadhir, & Kareshki, 2015).

Kwame and Petrucha (2020) noted that, if nurses understood culture and communicated well in their practice and especially in relation to nurse-patient communication, it would contribute to kins and patients engaging and having better perceptions of quality care. Both nurses and patients would bring their individual respective knowledge, attitudes, feelings, experiences, and patterns of behaviors to the nurse-patient relationship. Hence these individual-based behavioral

impressions and perceptions of reality in healthcare setup would require diverse communication styles to be applied in order to meet the different healthcare expectations and needs of patients and their kins. In these individual and collective perceptions are implanted decision-making rights, exchange of information, and socio-cultural concept of self identity. All these have indications on communication processes and outcomes of social interactions. A significant number of culturally diverse patients were frequently noted to be having communication challenges during healthcare delivery, specifically when socio-cultural disparities were fully welcome, valued, traversed or comprehended (Kaihlanen, Hietapakka & Heponiemi 2019).

Haverinen (2017) noted pediatric Critical Care nurses regularly encountered challenges in intercultural interaction; however, the nurses registered a positive outlook concerning their experiences in intercultural families. Intercultural communication was challenging but the nurses had a positive outlook towards encountering intercultural families. On assessment of the nurse competence, they had high preference and knowledge base on cultural competent care

2.4.2 Faith, Religious and Cultural Beliefs

Culture can influence everything from how people view conventional medicine to their comfort with a health care worker of the opposite gender. It is asserted that one's culture has an inseparable and meaningful relationship with health needs, care, and outcomes Melissa et. al (2020). Persons with divergent cultures are characterized by distinctive beliefs, values, and practices. The disparities make it a challenge to provide healthcare that incorporates every person. Some religious groups do not believe in given treatment types whereas other individuals may react to pain, and illness in distinctive ways. Individuals working in health settings, specifically nursing, should be aware of cultural disparities, and employ sensitivity whenever

treating individual patients. Concerns arising for nurses entail faith, and religious beliefs (Kim 2020).

Specific religious groups might reject prescription medications, surgeries, blood transfusion or other possible lifesaving treatments due to their religious beliefs. Nurses might strain to comprehend the beliefs, and might disagree with the patient's autonomy to resist such treatment. That is the reason why developing sensitivity toward several religious beliefs is very critical. A nurse ought to enquire from the patient, and attempt to comprehend better, their beliefs so that they can accommodate their stances, and if possible, work around traditional treatment options. That additional step may significantly enhance the patient's experience, and association with the healthcare staff (Kim 2020). A study done by Willemse et al., (2020) on spiritual care in CCU reveals that spiritual care is not yet systematically integrated into daily patient care.

Nurses have the feeling that offering care to ethnic minority patients' cohort impacts their workflow, and period required for care delivery. Besides, the expenditure incurred in hiring interpreters is a source of stress to nurses, and patients. They felt that multiculturalism had an influence in the provision of health care with regards to values, beliefs and practices, linguistic affiliation and health literacy status of patients (Atanga & Ayong 2017).

Suarez et al (2020) in their study reckoned that bicultural Latino nurses were hired not fill the Registered Nurses' shortage or to take undesirable jobs shunned by native workers but as cultural brokers to facilitate "culturally competent care" in a predominantly white institution that serves an increasingly diverse patient population. Hispanics had become the majority-minority group. These nurses knew both cultures thus were able to successfully engage in cultural brokerage. They were put in a workplace context and were expected to adhere to professional norms and

organizational regulations while simultaneously addressing their co-ethnic patients' cultural understandings, practices, and other life-context concerns. According to Haverinen (2017) in his study, he indicated that unilateral interaction and individual capabilities, and abilities of nurses significantly affected multicultural communications. There was willingness from nurses to work in a culturally sensitive way to minimize marginalization of the families, and enhance their perception of equal, and quality healthcare. If the nurses were unable to communicate using words or signs, they could be present in the situation then, maintenance of eye contact with a patient or use kind gestures were noted as essential segment of non-verbal communication (Haverinen 2017). To address challenges faced during multicultural transactions, nurses need to practice self-criticism and tolerate differences, develop interpersonal and psychological skills, and collaborate with other staff and patients' kins (Shahzad, Ali, Younas, Tayaben, 2021).

In critical care units, the different multicultural backgrounds of kins and health-care workers oftenly results in communication challenges and conflict. This may cause family stress and health provider burnout. Guidance on prevention of these conflicts as provided by some Critical Care societies is; focusing on good communication and understanding between patients' kins and the caregiver team (Metaxa, & Ely, 2020).

2.5 Nursing Code of ethics

Key ethical principles to nursing are beneficence (obligation to do good) and non-malfeasance (obligation to avoid doing harm), justice, autonomy, veracity, and fidelity. Applying the principle of beneficence and non-maleficence is expected for all nurses. Sometimes, it might be tricky to weigh duty of beneficence and duty of non-maleficence. In some context, the duty of maleficence becomes stronger than the duty of providing benefit. The nurses need to be aware of the limit of their obligations to do good and avoid harm in patient care. The nurses are obliged to

treat equals in an equal proportion and unequal in a different way as per need. The nurses should respect patients as an autonomous individual and respect their choice of decision. The nurses are supposed to tell the truth and not to deceive patients and their relatives in healthcare. The nurses are obliged to remain faithful (Shrestha 2021)

2.6 Theoretical framework

2.6.1 Madeleine Leininger and the Transcultural Theory of Nursing

Dr. Leininger's most significant and unique contribution was the development of Culture Care Diversity and Universality Theory. She introduced it in early 1960s to provide culturally congruent and competent care (Leininger, 1995). Madeleine believed that transcultural nursing care could provide meaningful and therapeutic health and healing outcomes to the sick. In the theory development, she identified transcultural nursing concepts, principles, theories, and research-based knowledge to guide, challenge, and explain nursing practices. This was a significant and new contribution to nursing and has been an important means to open the door to advance new scientific and humanistic dimensions of caring for people of diverse and similar cultures. This culture care theory use has greatly expanded nursing's knowledge base about multicultural societies in the world. This Theory was evolved in order to establish a substantive knowledge base to guide nurses in discovery and use of the knowledge in transcultural nursing practices. Dr. Leininger envisioned that nurses would need transcultural knowledge and practices to function with people of diverse cultures worldwide (Leininger, 1970, 1978). This was the post–World War II period, when many new immigrants and refugees were coming to America, and the world was becoming more multicultural.

2.6.2 Three Modalities

Leininger identified three new creative ways to attain and maintain culturally congruent care. The three modalities suggested were (1) culture care preservation or maintenance, (2) culture care accommodation or negotiation, and (3) culture care restructuring or repaterning. The three modalities were very different from the traditional nursing practices, routines, or interventions. They focused on ways to use theory data creatively to facilitate harmonious care suited to clients' cultural needs. The care had to be tailored to fit the client needs. Leininger believed that routine interventions would not always be appropriate and could lead to cultural imposition, cultural tensions, and cultural conflicts. Thus, nurses had to shift from relying on routine interventions and from focusing on symptoms to care practices derived from the clients' culture and from the theory. Holistic care and knowledge from the theory and not medical data was to be used and also both generic and professional care data. Though a new challenge, it was rewarding for the nurse and the client if prudently done. The use of the theory has brought new kinds of transcultural nursing knowledge that have been forthcoming. There has been discovery of culturally based care to prevent illness and maintain wellness. More important, cultural differences and similarities have been discovered with the theory (Leininger, 1995).

According to Melissa, Douglas, Robin, Rachel and Steven (2020) every individual/patient has a clear view of the world, guided or influenced by their cultures. Culture is difficult to define but, Leininger described it as the learned, shared, and transmitted values, beliefs, norms, and way of life for a particular group of people that guides their thinking, decision making, and a patterned way of acting that most often are intergenerational. Clients view promotion of health and treatment through their own cultural lens, which will impact their overall health.

The Madeleine Leininger Model is a model is used by nurses in evaluating cultural patients. It connects the concepts of the theory with clinical practices on the ground, and offers a structured approach to link morals, faith, behaviors, and group customs. The model encompasses many areas of a culture: religion, finances, social, technology, education, legal, politics, and philosophy. All these together with language and social environment, powerfully influence services delivered by systems.

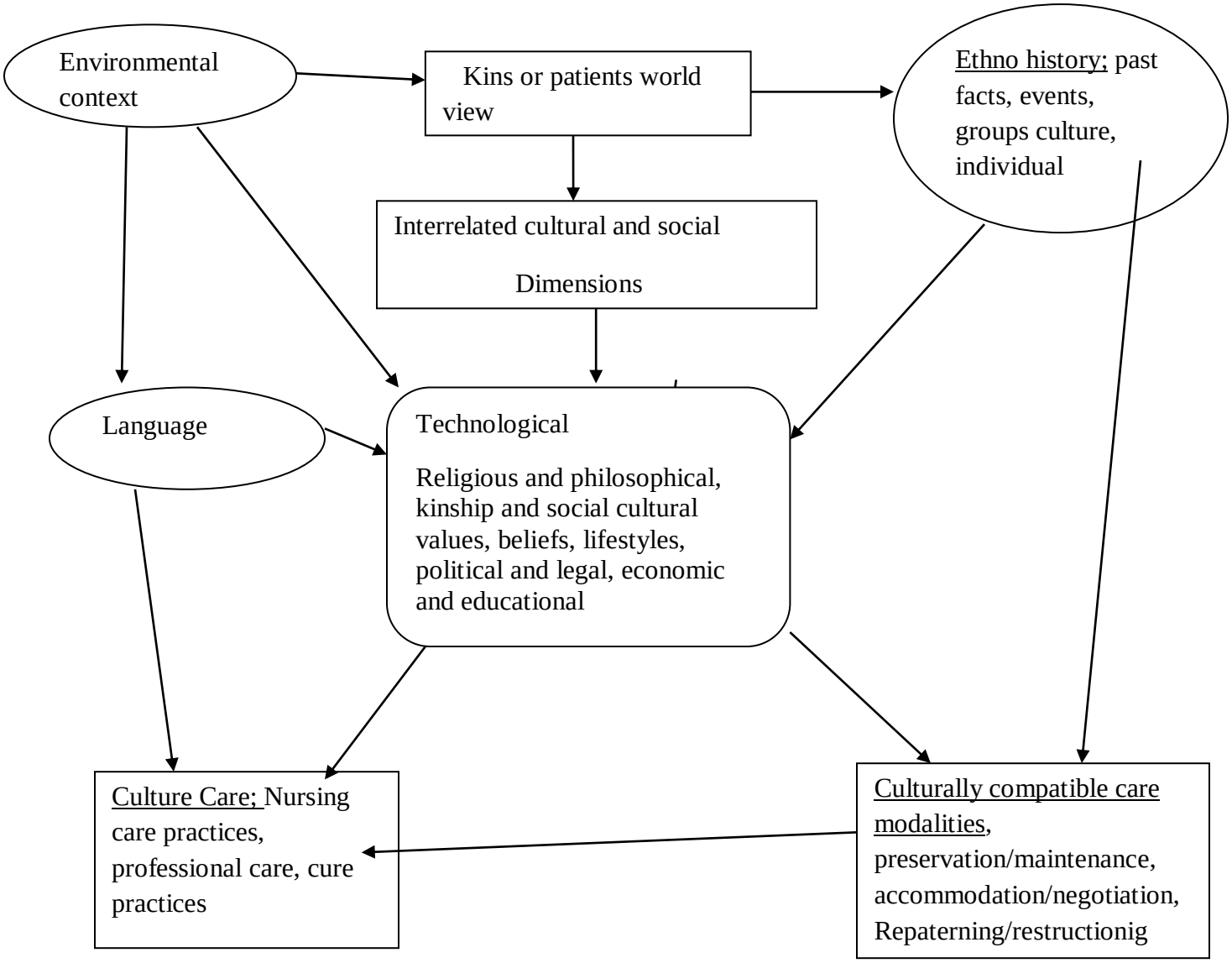
2.6.3 Theory Application

Customary systems of health care are based on traditional trusts related to health. Professional systems rely on acquired study, practice that is evidence-based, and research. Patients' physical, spiritual, and cultural needs are always considered by the profession of nursing. A rigorous comprehension of these needs eases the achieving of wanted patients' results. This model assists professionals in health care to keep away from patient stereotyping.

To achieve these goals, the model uses these three ideas: maintenance of culture care /conservation, negotiation of culture care /accommodation, and culture care remodeling/repaterning. Preservation of culture means that nurses' are in support of some beneficial cultural practices like, acupuncture for pain and anxiety relief before the medical treatments are instituted. Assistance given to patients to perform cultural activities that do not pose any danger to their health and to any other person including staff is referred to as cultural negotiation. Cultural restructuring is the effort nurses put to give care centered to the patient by aiding them to adjust or change unhealthy activities or those that are detrimental / harmful to their health or to those in their surroundings (Albougami, Pounds & Alotaibi 2016).

Madeleine Leningers Sunrise Model (Fawcett 2018).

2.7 Theoretical Framework



Madeleine Leininger's Sunrise model (Fawcett 2018).

The theory's main focus is for nursing care to fit with or have beneficial meaning and health outcomes for people of different or similar cultural backgrounds.

2.7.1 Explanation of the Theory Framework

The framework represents the structure of culture care theory by describing the relationship between anthropological and nursing practice beliefs and principle. It is borrowed from Madeleine Leininger's sunrise model which is used when making patient's cultural evaluations. The concepts of the framework's are inter-connected to the theory with actual clinical practices and offers a systemic approach to identifying values, beliefs, behaviors, and community customs. Each culture has its own way of viewing the world and has cultural and social structure learned through the language spoken and the contexts of the environment. The contexts are technological factors, religious and philosophical factors, kinship and social factors, cultural values and beliefs political and legal factors, educational factors, and economic factors. All these together with language and environmental contexts determine the care and patterns of health and the way people express themselves, families, groups, and institutions; all these will participate in various health systems, (both folk and professional systems) (Albougami, Pounds & Alotaibi 2016).To provide culture sensitive care, nurses use knowledge acquired from the model to make decisions on cultural care preservation/maintenance (support for cultural practices such as acupressure or acupuncture for anxiety and pain relief medical treatment), cultural care accommodation/negotiation. This provides patients and family members ability to perform cultural activities that do not cause threat to the patient or any other person health in the unit. The last one is cultural care repaterning/restructuring, and this is efforts to deliver patient-centered care by helping them to modify or change their cultural activities. This is suggested when there are cultural practices that may be harmful to the patient or to others in the surrounding environment. The Leininger's model assists healthcare professionals to avoid patient stereotyping. (Albougami, Pounds & Alotaibi 2016).

2.8. Literature summary and Gap

To the best of my knowledge, Critical Care Nurse's multicultural transactions with critically ill patients have not been explored in CCU of KNH or any other critical care units in Kenya. There are very limited studies that have explored critical care nurses' cultural competences in the Sub-Saharan region and literature that was reviewed was mostly from the developed world and Asian countries.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

In this chapter the researcher outlines in details the proposed methodology that was adopted in completing the study. The sections covered included; the study design, study area, population, sampling criteria, methods of data collection, analysis and ethical considerations.

3.2 Study Design

A descriptive phenomenological study design was employed where nurses gave their own lived experiences in multicultural transactions with critically ill patients' kins. This design is suitable for understanding views and perceptions and helps discover new thoughts and individual views. The goal of descriptive phenomenological design is to produce a rich description and in depth understanding of the phenomenon of interest, cultural or lived experiences of people in their natural setting (Khan 2014). The design was appropriate for this study because individual perceptions and experiences are varied and in depth interviews provided rich information regarding nurse's multicultural transactions. The phenomenon description was done as guided by Colaizzi's (1978) method which according to Wirihana et al. (2018), the phenomenological method by Colaizzi can be reliably used to study experiences of people and help come up with therapeutic policy and provide patient oriented management.

3.3 Study Area

The study area was the main CCU in KNH. The study area was chosen due to its large capacity and accommodates more patients than the other supplementary CCUs and also due the large number of critical care nurses deployed in the unit. KNH is the largest teaching, referral and research hospital in Kenya. It is situated in the capital city of Nairobi along hospital road in Upper hill. It has a bed capacity of one thousand eight hundred (1800) and receives patients from

within Kenya as well as within East and Central Africa. KNH has one main critical care unit with a bed capacity of 21. It has other subsidiary CCUs namely, Neonatal Intensive Care Unit, Pediatric Intensive Care Unit, Medical Intensive Care Unit, Cardiology Intensive Care Unit, Neurological Intensive Care Unit and Reproductive Health Intensive Care Unit. Main CCU was chosen because of it's high capacity of patients and hence a wide mixture of cultures. It also has a large number of nurses compare to the other supplementary CCUs.

3.4 Study Population

The study population was nurses working in Critical Care Unit providing direct patient care and also interacting with their Kins.

3.4.1 Inclusion Criteria for nurses in CCU

-The study included nurses working in CCU who provided direct care to critically ill patients who consented to participate in the study voluntarily with no coercion.

-The study included nurses who had worked for a minimum of two years in the unit and were good informants and could eloquently express themselves.

3.4.2 Exclusion criteria for nurses in CCU

- Nurses who declined to consent to participate in the study
- Nurses who were on leave and sick off since they were not available during the recruitment phase which was done physically.

3.5 Sample Size Determination

The study sample size was not be pre-determined but was guided by data saturation. This meant that the participants were interviewed using the same tool guide until a time that no new

information was forthcoming and redundancy was achieved. The goal was to generate enough in-depth data that illuminated the patterns, categories and dimensions of the phenomenon under study. Phenomenological studies tend to rely on very small samples, often ten (10) or fewer participants (Polit & Beck 2017).

3.6 Sampling Procedure

Participants were selected using purposive sampling that meant selecting participants that gave beneficial information for the study and had experienced the phenomenon.

3.7 Participant recruitment

The researcher posted a flyer of the study to the study area (main CCU) with contacts. By use of a flyer, participants enrolled willingly for the study and this eliminated coercion and biasness. Those interested contacted the researcher who verified if they met the inclusion criteria. If they met the inclusion criteria then the researcher took their contacts met them at an agreed time. They were explained about the study in detail and those who agreed to consent to participate in the study were recruited.

3.7. 1 Participant Consenting Procedure

Upon authorization by the relevant bodies, the nurses willing to participate in the study were approached at a convenient time and were taken into a private room. The researcher explained to the participants the crucial aspects of the study including study background, nature and objectives, the purpose of the study, the implications of participation in terms of benefits, utility and risks that may result due to taking part in the study using an informed consent form. The potential participants were allowed to ask any questions and to clarify any aspects relating to the study. They were also informed that participation was voluntary. Those who consented to

participate were taken through the statement of consent declaration. Once the participant expressed an understanding of the terms agreed, they were be given the consent form to sign.

3.8 Data collection

3.8.1 Research Instrument

The researcher used a pre-tested interview guide to collect in-depth information through in-depth interviews. The interview tool was researcher generated and more questions arose during the in-depth interview based on literature and participants responses.

3.8.2 Pre-test of the Study Instrument

Pre-testing of the study instrument was done in medical critical care unit which has similar characteristics as the study area with two nurses (2). This was to evaluate time that the interview would take and whether the questions were well understood by the participants. This was also helping the researcher to know whether the questions were objectionable and well understood by participants. These participants were not included in the main study. Data collected was analyzed and necessary corrections effected. Expert advice was sought to improve the study instrument.

were used during data collection (Anney 2014). The validity of this study was ensured by member checking which was used to enhance credibility. Audit trails and peer referencing were done by sharing and discussing the verbatim

3.8.3 Data Collection Procedure

Data was collected from the main CCU from nurses who had worked in the unit for a minimum of two years. Only participants who had consented were recruited for the study and individually took part in the 30 to 45 minutes in-depth virtual interview. Permission to audio recording the interview was sought from the participant.

An interview guide was used to guide the researcher during the in-depth virtual interview session with the study participant to coordinate the discussions and ensure the relevant information was captured. The guide outlined how the interview was to be set up including structured probe questions, follow-up questions and finally exit questions. The questions were simple, short and clear and avoided any biasness and ensured quality. Audio recorded interviews enabled researcher to concentrate on participants responses (A Meadows, 2003). All the sessions were audio and video recorded and field notes were taken during the interview to ensure quality.

3.9 Data Management plan

3.9.1 Data Management

Data management is preparation of data for analysis by performing checks to ensure that data are consistent (polit and Beck 2017). The audio recorded data was transcribed verbatim on a daily basis as data was collected. This was done by cross checking the transcripts with the audio recording to ensure accuracy. The transcribed data was kept safely in a computer that was password protected only accessible to the researcher.

3.9.2 Data storage

The Principle of participant's anonymity was maintained by ensuring that all interview notes, transcript print outs and audio recordings were allocated continuous serial codes and stored in a cupboard under lock and key. Besides, any soft data entered in the computer was protected by a password and was only accessed by the principal researcher. The transcript print outs was locked away in a filing cabinet and the keys to the filing cabinet were only handled by the researcher to ensure confidentiality. The audio/video records were save in a computer that was password protected and also saved in Google drive.

3.9.3 Data analysis, presentation and measurement

According to Parahoo, (2006) data collection and analysis are done at the same time and after the interview. Demographic data was keyed in the computer Statistical Package for Social Sciences (SPSS) and analyzed descriptively by summarizing the socio-demographic data and clinical characteristics using measures of central tendency and dispersion

The researcher during data collection wrote notes which captured key elements from the interviews to create a well enhanced understanding of each response. This was research log that the researcher used. Participant identification code was developed with key emphasis on date of the interview and the position of the interviewee. All of the interviews that were captured were recorded and the interviewer indicated the start and the end of the interview. The audio recorded interviews were saved in Google Drive to avoid unintentional loss.

Transcription was done verbatim. The researcher audited every transcript against the original audio repeatedly reading the typed transcript and comparing the content to the audio-recording. This ensured high level of familiarity with the data and gained confidence in its overall trustworthiness and accuracy of the analysis. The transcripts were then imported to NVivo 11 to allow for organization of the data and ensure easy development of themes. Content analysis was used identify the main themes and subthemes. Direct quotations from the transcribed text were also used to ensure that the perspectives of the participants are represented as clearly as possible in the study findings. There were five major themes that were identified. The study identified five main themes which include restrictive cultural beliefs in CCU, nurse's responses in care, limitation to care in multicultural setting and enabling practice.

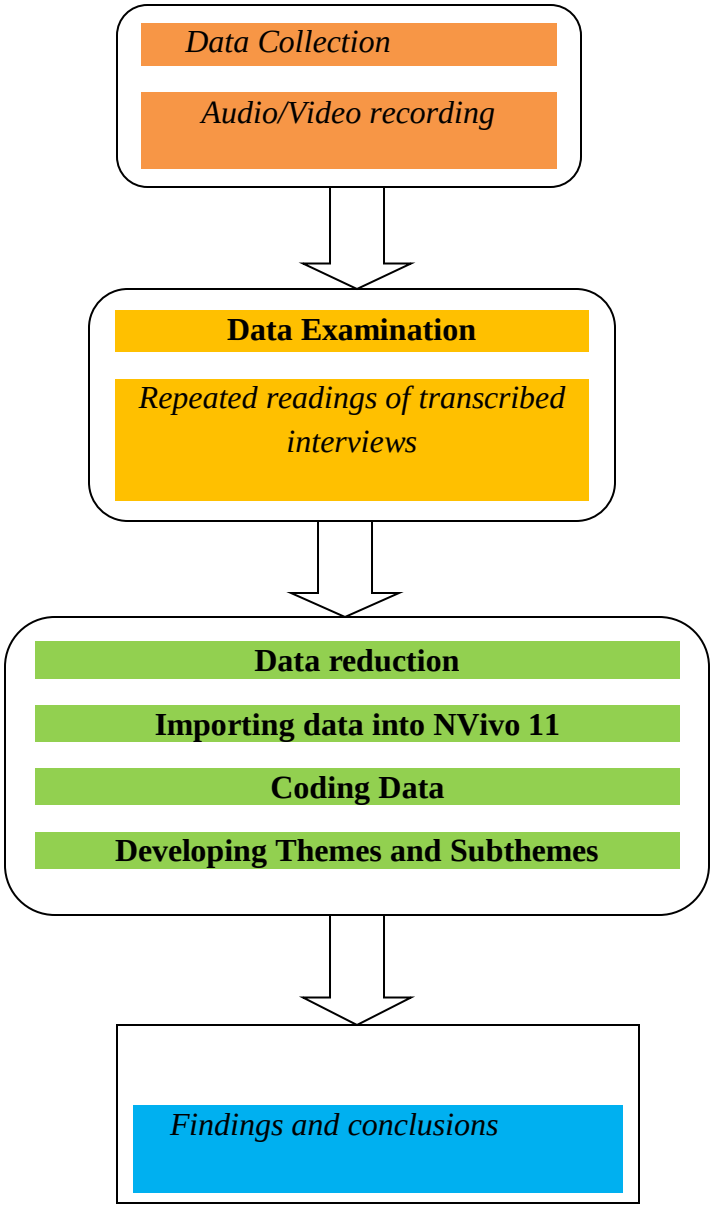


Figure 1: Data Analysis framework- (Source, Author, 2021)

3.10 Robustness of the Study

Rigor involves strive by the researcher for excellence and how they adhere to detail and accuracy. (Parahoo, 2006) state that researchers want their findings to reflect truthfully the phenomenon they are studying and to contribute to knowledge that is beneficial to others. The researcher proposes to use a framework by Lincoln and Guba (1985) as cited in Parahoo, 2006 and Polit and Beck (2017) to increase the trustworthiness of this study. This included credibility, dependability, confirmability and transferability. Credibility is the confidence in the truth of the data and interpretations of them. According to Polit and Beck (2017) it is considered by Lincoln and Guba to be a fundamental goal of qualitative research. Member checking is deemed an important technique for establishing credibility in qualitative research. This was done by continually checking, questioning and theoretically interpreting the findings to ensure that the study has fulfilled its research aims. Dependability is the ability of the data to remain stable over time. The researcher used an audit trail to enhance the dependability of the study. Confirmability is the ability of data representing the information participants provided by clarifying all information. The researcher used verbatim text quotes from participants that reinforced conclusions to affirm confirmability. An audit trail, was maintained by documenting the steps that were taken and decisions made, that could be followed by another researcher in future studies. Transferability is the extent to which the findings of a qualitative study can be useful to similar groups or situations (Parahoo, 2006). Given the small sample size the issue of generalizability arises. Parahoo, 2006, said that if the study is carried out well it can be of significant value beyond the sample studied. Usually qualitative study findings are not generalizable but may have meaning or resonance with others in similar situations (McKenna and Copnell, 2019). The researcher adhered to proposal protocol while conducting the research

to ensure transferability. In this study it was predicted that data saturation ensured data completeness and that key aspects of a phenomenon are captured for interpretation. The study was able to answer the research questions.

3.11 Logistical and Ethical Considerations

- Clearance and approval for the study was sought by presenting the study proposal to the KNH-UoN ethics review board approval number (P411/05/2021).

- Voluntary informed consent was sought from the participants by the researcher before participation.

- Participants were briefed on their rights, potential benefits and risks before they participated in the study and there was no coercion or incentives given to participants.

- Participants identity was not indicated on any interview notes.

- Transcript print outs and audio recordings were stored in a cupboard under lock and key and password protected computer.

- The contact of ethics review committee and supervisors were availed to study participants for any clarification.

- The participants understanding of the study was ensured before they signed the consent forms.

- Any conflict of interest regarding this study was confirmed and the participants were also asked to confirm if they had any conflict of interest.

- The participants were assured of the right to withdraw from the research process when they felt they were pressured or coerced in any way or their rights were violated.

- Respect was assured to the participants by giving due diligence to a person's judgment and ensuring that the participant was free to choose without interference.

- Data stored on computer was protected by a pass word only known to the researcher. Data was destroyed after completion of the study.

- Informed consent was ensured both for the study participation and for audi recording.

- Kenyatta National Hospital management and CCU head of department were requested for permission to conduct the study.

- There was strict adherence to Ministry of Health COVID-19 prevention protocols during the recruitment exercise and due to the same in-depth interviews were conducted virtually. A social distance of 1.5 meters was maintained during the recruitment and it was ensured that all participants had a mask and it was ensured that they washed hands or sanitized before handling the forms. The researcher adhered to the same protocols.

3.12 Dissemination plan

The findings of this study will be sent to KNH-UoN research ethics committee and University of Nairobi School of Nursing Sciences library. Later the study report will be uploaded into the University of Nairobi repository platform. The researcher will present the findings to CCU staff in one of their continuous medical education sessions and also endeavor to present in appropriate academic and scientific conferences and also publish in relevant journals

CHAPTER FOUR: RESULTS

4.1. Introduction

The researcher investigated nurses' multicultural transactions with critically ill patients' kins and its impact on quality of care at KNH CCU. The specific objectives that were included in the study involved describing the specific aspects of multicultural transactions with critically ill patients 'kins in KNH CCU that critical care nurses perceive to impact on quality of care, to explore nurses' competence on multicultural transactions with critically ill patients' and to identify the challenges nurses face in multicultural transactions with critically ill patients' kins in KNH CCU. In this chapter, the researcher presented findings of the study based on the study objectives. The chapter starts with the socio demographic factors of the participants presented in table form followed by, the participants' definition of culture and the themes that emerged from the study with the responses of participants from each question.

4.2 Socio-Demographic Characteristic of Study Participants

The findings showed that, 66.7% (n =6) of the study participants were female. The average age was 46years; the minimum age of a participant in the study was 34 years while the maximum was 54 years. Majority were married, 77.8% (n =7), 66.7% (n =6) had college level education. The years of experience analysis showed that the average years of service was 16 years among the participants. The minimum years of experience of a study participant was 4 years while the longest serving nurse who participated in the study had worked for 28 years as shown in Table 1.

Table 1: Socio-demographic characteristics

Demographic characteristics	Frequency (n)	Percent (%)
Gender		
Male	3	33.3
Female	6	66.7
Age Mean (Min - Max)	46(34 - 54)	
Marital status		
Single	2	22.2
Married	7	77.8
Education level		
College	6	66.7
Degree	2	22.2
Masters	1	11.1
Years of Experience Mean (Min - Max	16 (4 - 28)	

4.2. Participants' Definition of Culture

Participants in the study defined culture uniquely although the underpinning components have been maintained relatively similar among all participants which illustrate their knowledge of culture. Their responses were;

> ***Participant 1*** *"Culture, I think, is a set of behaviors that is common in a given demographic population."*
>
> ***Participant 7*** *"I would define it as the norms as people usually share and how people carry themselves depending on how they've been brought up. It's their way of doing things bringing diversity in terms of religion and tribe."*
>
> ***Participant 8*** *"They are beliefs a person has that are connected to the community the person comes from."*
>
> ***Participant 9*** *"Culture stands for the norms and beliefs of an individual, it could be within the working station, based on individual tribe or religious based."*

The themes that emerged from the study were as shown below in the codebook;

Table 2: Themes

Objective	Theme	Subtheme	Description
Describe the specific aspects of multicultural transactions with critically ill patients' kins in KNH CCU that critical care nurses perceive to impact on quality of care.	Restrictive cultural beliefs	• Medical processes and procedures • Gender stereotypes in care • Restrictive Visitation from family members	Participants explain kinds of cultural or religious beliefs that they have encountered in CCU while providing care
	Nurse personal culture influence on CCU Care	• Nurse personal culture influence • Lack of personal culture influence	Participants describe whether their own culture influences the care of a critically ill patient. The participants also explain how they integrate patient's culture into their care.
Nurses' competence on multicultural transactions with critically ill patients' kins in KNH CCU	Nurses responses on cultural awareness in care	• Cultural knowledge in healthcare • Need for training in cultural care	Participants explain whether they are culturally competent in provision of care on multicultural transactions. Participants explain whether training on cultural competence is crucial in provision of care on multicultural transactions

The challenges nurses face in multicultural transactions with critically ill patients' kins in KNH CCU	Limitation to care in multicultural setting	• Difficulty in management of the needs of relatives. • Linguistic barriers • Poor health literacy among relatives	Participants explain the impact of relatives' culture on the quality of care given to patients. Participants explain different challenges that they face in multicultural transactions.
	Enabling practice	• Educating Kin's • Engaging multidisciplinary agency • Counselling and training of nurses in CCU	Participants explain ways to enable effective care delivery in multicultural transactions

4.3. Theme1: Restrictive cultural beliefs in CCU

The participants involved in the study identified varied cultural beliefs which were dominant in CCU. The common beliefs that were identified included restrictive visitation of patients by their relatives, strong advocacy against blood product transfusion and also against surgical procedures.

4.4.1 Subtheme 1: Medical processes and procedures

Most of the participants identified that many of the relatives were against some surgical procedures and transfusion of blood products. This was majorly informed by strong religious influence where members of certain religious sects were against blood transfusion and some surgical procedures.

> ***Participant 1*** *"We also have a group of religious people who don't believe in some surgeries like part of their bodies being cut. For example, tracheostomy. Another one I*

can think of is some cultural beliefs where you'll find some people believing a patient who is comatose is already dead so it poses a problem when you're giving care."

Participant 4 *"There are those religions that do not believe in Blood transfusion like the Jehovah's Witness and the patient may require blood transfusion so it becomes a challenge managing such a patient and it becomes a dilemma in giving the care because you have to seek other avenues of treating the patient."*

Participant 6 *"my worst scenario was when we had a teenage boy who was on a ventilator, and he could not talk for himself and needed blood transfusion. The mother came in saying, "no you cannot transfuse my son, he is a Jehovah's Witness'' but deep down we knew that is what would help the boy.*

Participant 7 *"Another issue is among the one community who believe if someone has passed, they should be buried on the same day or early the next day but it takes long for a body to be cleared in KNH and this becomes a challenge, especially for the person on the ground as the family becomes very upset. You just have to explain that there is a protocol to be followed and that it is not your wish to delay them."*

Participant 9 *"For the cultural beliefs, some of the tribes in Kenya, lack understanding. There was a patient I encountered who was anemic and the family could not understand that patient was lacking blood yet in their culture, it is as easy as getting blood from a cow. They believe if a person drinks blood, it goes into circulation. That one is a belief secondary to knowledge deficit, maybe nobody took time to explain to the relatives what anemia is and how drinking blood does not help."*

4.4.2 Subtheme 2: Gender stereotypes in care

Some of the participants noted that in some communities, gender was a major factor in delivery of care.

> ***Participant 2*** *stressed that, "One of the cultural beliefs I found with the Somali community is that you as a male nurse are not supposed to take care of a female patient. It had reached a point where even the nursing officer in charge allocates female nurses to female patients. Some activities like bed baths are critical in CCU and for instance where there's only a male and female nurse, yet it takes two people to clean the patient, it becomes a problem and this eventually affects quality of care. Additionally,* ***Participant 2*** *continued that, "There are some set of cultures that also affect the discharge of patients. For example, once a patient dies, the Somali community has no time to wait for you to follow the proper protocol to be followed."*

4.4.3 Subtheme 3: Restrictive visitation

Majority of the participants identified that relatives of patients in CCU most times limit the number of relatives that visit the patient. This was identified as mainly contributed by fear of the unknown and witchcraft and participants asserted that;

> ***Participant 5*** *"There are times when a patient is in the unit, the relatives may come and say they don't want their patient to be seen or visited by certain people and it becomes an issue because you don't know how to regulate the relatives." The participant further added that, "Maybe they don't trust those people who are coming to visit their relative. They feel maybe they are the cause of the illness or they have contributed to the illness and they don't want them to come and see the patient."*

Participant 6 *"Some people believe their relatives are unwell because of getting married to a certain community because intermarriages between the communities are discouraged and unless they separate, the patient will not improve. Family beliefs like not intermarrying because of certain reasons like witchcraft."*

4.4. Theme 2: Nurse personal culture influence on CCU care

Nurses are in a position of influence in delivery of care in CCU, thus they are involved in different decision-making processes. Nurses will always do what is right for the patient without discrimination of which culture they come from because that is what was instilled in their discipline, to be ethical, to do no harm and to do justice.

4.5.1 Subtheme 1: Nurse personal culture influence

Some of the nurses stated that sometimes they found their culture influencing the care given to the critically ill patient where relatives are unable to make conclusive decision. This is mainly in situations where healthcare provider and patient conform to a similar cultural aspect.

4.5.2 Subtheme 2: Lack of personal culture influence

Most of the participants in the study asserted that they will seek consent from kins for certain conventional procedures. Even if the kins are opposed, the nurse will go ahead and fight for the rights of the patient by following the right channels and involving others in the decision making for the benefit of the patient. So even if it takes long which sometimes it does the patient will still get their rights. Participants stated that;

Participant 6 *"I would say mine is not so tied up, where I come from we are not so attached to beliefs. So, I don't have point blank beliefs that would influence patient care.*

Like those who come and say the patient is suffering so they want to remove the ventilator, they'll even screen the patient and might disconnect the ventilator. Where I come from, we don't have those heavy things…we are able to let things go. When I take care of my patients, I know I'm doing the best for my patient, if they improve am happy, if they die its God's will."

The respondents were also asked whether they have seen other healthcare providers trying to impose their culture on care delivery process and they said;

Participant 7 *"Not really. It would probably only come in when I'm attending to someone like my mother who I'll be shy doing some things but for the others, I can do anything within the ethical boundaries."*

Participant 7 *"It's rare because I cannot quite remember seeing somebody who is a medic that was trying to impose their culture or beliefs on the care of a patient."*

4.5. Theme 3: Nurses responses in care

The participants were also asked about their competency on multicultural transactions with critically ill patients. The subthemes that were identified include cultural knowledge and need for training to enhance cultural competence among nurses.

4.6.1 Subtheme 1: Cultural knowledge in healthcare

Many of the participants felt that they have low cultural competence which limits their ability to handle each situation critically and improve patient outcomes. Their responses were;

Participant 4 *"When you're faced with a particular problem, you may feel inadequate, for example with the Jehovah's Witness, I have not gone deep into it to understand them but if we can be able to learn more about multicultural beliefs, we can be able to handle*

situations as they come without being anxious about their beliefs or the outcome of care."

Participant 8 *stated that, "Sometimes I think I have the competence but other times you get challenges that would force you to involve other people, like the interpreters, even if you have the competence, you might not understand a certain language and also cannot ascertain whether the right thing is being communicated."*

Participant 9 *"I think there is a gap. One thing I have observed is the stereotype we have and we inculcate them for example, we understand the Muslims' culture and their belief in not prolonging life. If a patient comes and is affiliated with the religion, as the health worker, I already have a stereotype and an attitude towards them. This kind of sentiment tells you the health worker does not consider it important to find out more about that religion or culture meaning we don't understand a lot about that culture."*

Few of participants however, asserted that they have high level of cultural knowledge. This was informed by their knowledge on self-efficiency, diverse cultural practices and the uniqueness of the needs of patients and their relatives.

Participant 2 *"I have cultural competence as I understand myself. I am able to integrate different cultures to come up with quality care. For the rest, we have a long way to go and need them to have basics of cultural competence in natural care."*

Participant 5 *"I feel I'm competent because you just talk to the relatives and they express their thoughts and beliefs and you advise them further. Like in the case of Muslims, do not believe in their patients suffering, so if their patients are ill for a long time, they want to terminate their life and if you're not careful, they might try to suffocate the patient or disconnect the machines when they visit their patients."*

4.6.2 Subtheme 2: Need for training

Majority of the participants asserted that there exists a large gap in the level of nurse's preparedness in dealing with culturally diverse healthcare setting. This was mainly because many of the respondents felt that they knew little about most of the cultural aspects in different communities and religion hence had significant challenge in engaging relatives and patients. Their responses were

> ***Participant 4*** *"Yes, there is a major gap in my understanding and dealing with different communities. Training would be crucial so that we can be able to understand each other, where we come from, how we understand the patients and how to treat them with dignity without impacting our own cultures onto them."*
>
> ***Participant 6*** *"I think training would be good for nurses, like for example pregnant mothers who believe if they go to theatre, they will die they are able to be helped. That reminds me of a mother who was in CCU and was a do not resuscitate (DNR) and had a pregnancy and it was agreed that if the heart rate goes down, caesarian be done but culturally it was not acceptable. The husband had to be sat down and was told everything, what to expect and what could happen so that he could accept the child."*
>
> ***Participant 8*** *"No, not everyone has the competence. We all need training and even I would welcome that training. Sometimes you may even be imposing your culture on a patient without knowing it and training will help one see this and improve patient care, especially in CCU where the patient cannot talk and we deal with the relatives."*
>
> ***Participant 9*** *"I think there should be an intervention through health education or health talk or training on how to approach different cultures from us (nurses)."*

4.6. Theme 4: Limitation to care in a multicultural setting

The participants were asked about the challenges that they face in taking care of critically ill patients in multicultural transactions. The major limitations to care in multicultural transactions included linguistic barrier and spiritual affiliation and management of the needs of relatives.

4.7.1 Subtheme 1: Difficulty in management of the needs of relatives

The participants revealed that, many relatives have made it difficult to provide quality care as a result of their demands. Some of the demands are unachievable and focus is on provision of quality care and stabilization of patient in CCU. Participants stated that;

> ***Participant 1*** *"One of the challenges I said, those who believe everybody as their next of kin or their relatives, many times interfere with care because you're not able to deliver the care you want. They limit you in giving the care in that they are so many and at times it's even difficult to control them. Everyone wants to get in at their own time and so you find that the care you are supposed to be giving is interfered with by the frequent visits."*
>
> *Participants asserted that;*
>
> ***Participant 2*** *"I handled a female patient who happened to be a Maasai. The husband believed that only he should take care of his wife when she is unwell and therefore sent away all the other family members. He was so exhausted. Unfortunately, his wife passed on and we had to relay that message to him. The man happened to be unavailable and had refused the other family members to be contacted."*
>
> ***Participant 6*** *"Another scenario is with some men who are chauvinists and have found a female nurse. They cannot listen because as a woman you are supposed to listen and not talk or tell him anything. Sometimes it becomes very difficult because you have to look for a man to try and explain to them."*

Participant 6 *"The relatives already have their minds set and if you try to tell them anything different it is so hard. They become so noisy and they refuse to listen or understand what you're telling them. They get so angry and want to fight you and sometimes you have to involve the security personnel. We are also human beings and also get angry but you have to calm yourself down and remember that you are supposed to do what is best for the patient and move on."*

4.7.2 Subtheme 2: Linguistic barriers

The participants have also identified that communication has been a major challenge in striving to create a multicultural efficient healthcare environment. They said that;

Participant 2 *"Communicating with relatives is difficult sometimes they do not even understand Kiswahili which makes my work difficult."*

Participant 4 *"The lack of knowledge about the multicultural families and lack of knowledge on what other cultures believe in and what their beliefs are."*

Participant 8 *"The language barrier will not allow us communicate to the relatives the condition of the patient, or explain any procedures that have to be done."*

4.7.3 Poor health literacy among relatives

The findings from the study revealed that some of the relatives exhibited poor literacy level especially in the level of care and the protocols within a hospital setting. Most of them sought to prioritize their cultural and religious principles in hospital setting despite the hospital having its own clear operational guidelines highlighting the role of a relative or next of kin in provision of care. Participants maintained that;

Participant 6 *"The relatives already have their minds set and if you try to tell them anything different is so hard. They become so noisy and they refuse to listen or understand what you're telling them. They get so angry and want to fight you and sometimes you have to involve the security personnel. We are also human beings and also get angry but you have to calm yourself down and remember that you are supposed to do what is best for the patient and move on."*

Participant 9 *"For the cultural beliefs, some of the tribes in Kenya, like the Maasai, lack understanding. There was a patient I encountered who was anemic and the family could not understand that patient was lacking blood yet in their culture, it is as easy as getting blood from a cow. They believe if a person drinks blood, it goes into circulation. That one is a belief secondary to knowledge deficit, maybe nobody took time to explain to the relatives what anemia is and how drinking blood does not help."*

4.8 Theme 5: Enabling practice

The participants have presented varied ways that would be appropriate in helping deal with patient challenges to delivery of care in multicultural transactions. The main enabling practice measures that were identified by the participants include counseling, educating relatives and engaging a multidisciplinary agency to create a conducive environment for care in CCU.

4.8.1 Subtheme 1: Educating kins

The most common approach in management of challenges in multicultural transactions especially when dealing with kins is to educate them about the implications of their choices and why it is important to follow the defined care approach and thy stated that;

Participant 1 *"In such a case, if you're at the care giving point, you have to involve the team leader and the office in general, the in charge of the unit, the doctor in charge to talk to the ones involved and explain about the care they are refusing and why it is important. At times when we involve the others, many of them will tend to agree. They may not agree and allow the care to be given instantly but with time sometimes they get to see it and they allow the care to be given."*

Participant 9 *"One of the approaches is to have a conference with the relatives with a team of healthcare providers- the doctor, the social worker, the counselor. The situation is clearly explained to the family and health care worker to understand their point of view, misspelling the rumors and misconceptions. It might not take a short time but by the end of the day, an approach is found and the relatives take it positively."*

4.8.2 Subtheme 2: Engaging multidisciplinary agency

The participants also highlighted that there is need to include a multidisciplinary agency in dealing with most of these cultural based challenges and they noted that;

Participant 1 *"I think in cases of language barrier the hospital should be able to provide some interpreters or at least to know if you have such a challenge, where can you get somebody who can be able to help you to communicate to these clients. I think they can get interpreters who are fluent in a few languages that are found in our country."*

Participant 3 *"Sometimes the team leader who will also involve the consultant, the co-operate affairs and the legal office if the problem is so complicated and sensitive."*

Participant *"If there's a language barrier we try to get someone who can understand both languages so that they interpret."*

4.8.3 Subtheme 3: Counseling and training

Some of the participants have sort counseling services especially when dealing with difficult relatives some of whom are abusive, they said that;

> ***Participant 6*** *"I think it depends on individuals, how one is able to cope with what comes but when it goes overboard, I sit with someone who is close and I pour out my frustrations and I feel better. Sometimes you feel like you have a burnout and you seek professional help. There are times when if it's something involving everyone in the unit, we get counselors and we have group therapy and that also helps."*
>
> ***Participant 8*** *"we should have counselors who will help us know how to deal with different situations especially considering that culture is fundamental in African setting to improve care."*
>
> ***Participant 7*** *"Through counseling and having family conference meetings with the relatives can help solve these issues."*

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This section includes the discussion of the study findings in relation to past literature in comparing and contrasting the results.

5.2 Multicultural Aspects

Culture forms a fundamental aspect in the delivery of health care. Healthcare providers are required to remain committed in understanding the needs of patients and their relatives. This study sought to explore nurses' multicultural transactions with critically ill patients' kins in Kenyatta National Hospital Critical Care Unit. The findings have shown that five major themes were identified which included restrictive cultural beliefs, nurse influence on care of critically ill patient, cultural awareness in care, Limitations to care and enabling practice.

The findings from the study have shown that there are diverse cultural beliefs that limit the delivery of care in CCU. The common restrictive cultural beliefs that were identified in the present study were medical processes and procedures, gender stereotypes in care and restrictive visitation. The findings showed that, some of the kins were against medical processes and procedures. Blood transfusion and surgical procedures were the most common medical processes that were rejected. Religious affiliation was the most common reason leading to rejection of these medical procedures. Majority of the relatives of patients who were refusing these procedures belong to Jehovah witness which has been greatly known for their rigidity in blood transfusions. These findings are comparable to Swihart and Martin (2019) who found that majority of African religious grouping do not advocate for patient hospitalization due to their belief that God performs miracles and can heal even without going to hospital. Patients who are

comatose or unable to speak are faced with challenges because they are unable to make decisions pertaining to their care hence the relatives are left to decide on what needs to be done. Similarly in another study by Stafford et al., (2014) refusal of care due to religious principles was identified as a major problem among patients in critical care. There are kins that fail to observe visiting hours and visit patient at any time causing disruption to delivery of care. Matlakala et al., (2014) affirmed that relatives are a limiting factor to effective delivery of care in intensive care unit. Some of the relatives from different cultures failed to respect visiting rules of the organization or could not understand visiting rules and would often break the rules (Van Keer et al., 2015). There were kins from certain cultures that considered every relative as their next of kin and came in large numbers to visit the patient. According to Listerfelt et al., (2019), families from diverse cultures had extended family and a large number of visitors which included immediate family, relatives, friends and neighbors. The patient's room in critical care unit had no enough space to take in all the visitors at once.

The researcher found from study that gender chauvinism were a key cultural issue in delivery of care in intensive care unit. This was common among some cultural communities which still maintain a high patriarchal system where the roles between men and women are defined. These findings are echoed by a study conducted by Azad et al. (2020) which revealed that gender stereotypes are detrimental to delivery of care. The study further identified that there are still communities where men do not allow to be treated by women despite being in a hospital setting. Govender and Penn-Kekana (2008) also stressed that African communities maintain strong principles which have an influence on their health seeking behaviour and the choice of who to provide care.

The findings have also shown that a large number of the participants cited that many of the relatives create a restrictive visitation aspect where not every family member is allowed to visit the patients in the intensive care unit. This has been greatly necessitated by beliefs and lack of trust among family members. Witchcraft has also been identified as a key reason to restrictive visitation. Matlakala et al., (2014) asserted that thoughts about witchcraft influence the decisions among individuals in seeking care. Anyone who is accused of witchcraft is considered as an enemy hence making it difficult to be involved in care of an ailing person.

5.3. Nurse cultural competency in multicultural transactions

Nurses are directly involved in care process which places them centrally to issues pertaining the care of patients. The results showed that majority of nurses do not integrate the patient's culture in the delivery of care in CCU due the condition of the patient who is critically ill and most of the time it is about saving the life of this patient and so nursing ethics are adhered; the act of beneficence. These results are in line with Kaihlanen et al., (2019) who revealed that nurses are expected to maintain high level of ethical consideration and allow patients and their relatives to make important decisions. However, in our present study some of the nurses stated that there are situations where they intervene especially when the life of the patient is in danger Golden and Camaroff (2015) alluded there are times taboos and some everyday rituals that limit specific activities or direct certain behaviors, could be of harm to one's health and livelihood. Care delivery in CCU is complex because it deals with life saving situations that need quick action and requires healthcare workers critical thinking. In a study by Power et al., (2018) it was revealed that the patient's wellbeing is paramount and in situations where relatives do not agree on the best intervention, the healthcare provider should integrate their own critical thinking and make a decision that is appropriate. In this study one of the participants presented a case

involving a situation where the mother and father were unable to agree on the provision of care. In such situation healthcare providers can opt for a decision that produces the overall good and increases the chances of patients' survival. These findings are comparable to a study by Maharmeh et al. (2016) who stressed that critical care nurses have a significant role in provision of care and thus the decisions made by relatives should be assessed and inform the best good for the patient who is unable to speak for himself or herself. Further the study indicated that, critical care nurses are likely to be more confident and effective when dealing with patient's changing situations with more experience. In another study conducted in Tehran by Ramezani-Badr et al. (2009), it was found that, nurses used intuition and recognition of similar patient situations to diagnose the patient's health problem and give appropriate care. Although nurses are qualified to make such decisions, the researcher found that they would decide whether or not to carry them out based on the patient's risk-benefit and organizational requirements. This was due to the fact that nurses only had a limited amount of autonomy when it came to making judgments about a patient's health.

5.4 Cultural competency among nurses

Cultural competence in nursing is care that is responsive to diverse patient population taking into consideration cultural factors (e.g. language, communication styles, beliefs, attitudes and behaviors) that influence health and health care (Cruz et.al., 2017). The researcher's findings from the study revealed that, majority of the nurses had low level of cultural competency. This was based on the fact they were unable to effectively offer solutions to most of the cultural based issues that occurred during their care delivery. These findings are comparable to a study by Kaihlanen et al., (2019) which revealed that nurses had low level of cultural competency. However, these findings contrast those from Sherpherd et al., (2019) that revealed that nurses

had high level of cultural competency. The difference in this study and the latter would be as a result of the health system structure in Kenya and United States. United states are one of the highly culturally diverse countries in the world hence cultural competence is one of the criterions of employment unlike Kenya. In Kenya, there has been no great focus on cultural competency among nurses hence has remained a gap in healthcare delivery.

The participants in the present study revealed that need for training is a major requirement in improving the current situation. Since, healthcare professionals worldwide deliver care for increasing number of culturally and linguistically diverse patients. The importance of cultural competence is evident in terms of the quality of healthcare, and more knowledge is needed about different educational models and approaches that aim to increase cultural competence. Atanga and Ayong (2017) stressed that overcoming nursing care challenges in a multicultural care setting requires continuous training and constant review which present a well-organized context for improved level of care and service delivery. Nurses in today's multicultural society are tasked with delivering culturally appropriate care to immigrants (Cruz 2017). It poses challenges since it necessitates considering the patient's cultural demands in order to deliver excellent and satisfactory care. Nurses and health workers must acquire specific knowledge, skills, and attitudes in transcultural or cross-cultural nursing to improve health outcomes in a cultural context (Teixeira-Santos et al., 2021). Suk, Oh and Im, (2018) asserted that for visiting nurses who came to work in a multicultural set up, Institutional support was necessary to enhance their empowerment. This would assure them of the significance of their job and give them specific strategies to increase their empathy and improve their cultural competence. Regular systematic education on cultural sensitive care would help them provide culturally sensitive care to multicultural families.

5.5. Challenges in Multicultural Transactions

The researcher found that nurses face significant challenges in delivery of care in multicultural transactions. The main challenges included difficulty in meeting the needs requested by the kins who have many issues and ideologies. These challenges disrupt the quality of care delivered since most of the issues that relatives have are faith based, cultural and spiritual. These findings are in line with Brottman et al., (2020) which found that people have diverse cultural, religious and spiritual connections which are unique and thus integrating them in a care delivery creates challenges especially when there is insistence on their inclusion on care. Some of the religious groups do not believe in some treatment methods hence would want to dictate the care given to their relative regardless of whether there is an alternative or not. Similarly, Kim (2020) stated that the main challenges that occur in delivery of care in critical care include faith and religious based. Thus, in such situation, nurses may struggle to understand the ideas and may disagree with the patient's right to refuse treatment. That is why it is vital to acquire sensitivity to a variety of religious ideas. A nurse should ask the patient about their views and try to understand them better so that they can accommodate them and, if possible, work around typical treatment alternatives. That extra step could make a big difference in the patient's experience and relationship with the healthcare team.

The results also showed that language barrier was a major challenge among nurses in critical care. Some of the patient’s kins do not understand the national language thus cannot understand anything making it difficult for a nurse to communicate treatment decisions. These findings are comparable to those obtained from a study done in Finland by Kaihlanen et al. (2019) which found communication barrier being a leading barrier to delivery of quality care in CCU. Kwame and Petrucha (2020) also noted that communication is a major challenge in dealing with patient

relatives to provide care. Inability to communicate and interact effectively with relatives create a difficult situation where there is a significant need to provide quality care. Also according to Almutairi, McCarthy and Gardener (2015), communication barrier between patients/kins and health care workers may result to medical errors, substandard care, or even death. Consequently, it is extremely important to provide effective care to the culturally diverse patients in different cultural environments

The findings from the study also revealed that in controlling these challenges, educating relatives, engaging multidisciplinary agencies in communicating with relatives and as well as integration of counselling and training is essential in improving the multicultural environment among care providers in emergency settings. These was comparable to studies which found that the need for training critical care nurses and relatives is essential in limiting conflict (Atanga & Ayong, 2017;Teixeira-Santos et al., 2021).

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

The study identified five main themes which include restrictive cultural beliefs, nurse influence on CCU care, preparedness in care, limitations to care and enabling practice. The participants involved in the study identified varied cultural beliefs which were dominant in CCU. The common beliefs that were identified included restrictive visitation of patients by their relatives, strong advocacy against blood product transfusion and also against surgical procedures. Some of the nurses stated that they are involved in care and decision making in situations where relatives are unable to make conclusive decision. Many of the participants felt that they have low level of cultural competence Majority of the participants asserted that there is a large gap in the level of nurses' preparedness in dealing with culturally diverse healthcare setting. The results showed that the main challenges included difficulty in management of the needs of patient's kins. To control these challenges, it was identified that, educating relatives, engaging multidisciplinary agencies in communicating with relatives as well as integration of counselling and training is essential in improving the multicultural transactions among care providers in CCU.

6.2. Recommendations

6.2.1 Practice

The critical care unit should train critical care nurses on cultural competency to improve their interaction with relatives and patients in critical care unit. A multidisciplinary team should be incorporated in critical care unit that will take into focus the cultural needs of relatives to avoid conflicts with kins. The unit should ensure that counseling services are available all the time for critical care nurses to avoid negative attitude and constant conflict with patient's kins

6.2.2 Policy

A policy on multicultural transactions with patient's kins should be put in place through the act of parliament for the patient's benefit.

6.2.3 Further Research

There is need for further research on the knowledge, attitude and practice on multicultural Transactions among nurses in Critical care setting.

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APPENDIX

Appendix I: Time plan

Activity Timeline 2021	March	April	May	June	July	Aug	Sept	Oct	Nov
Proposal development									
Proposal defense									
Proposal approval									
Data collection									
Data analysis									
Initial Thesis draft submission									
Thesis defense									
Final research write-up									
Manuscripts development									
Article publication									

Appendix II: Budget

BUDGET COMPONENT	DESCRIPTION	ITEM	UNIT OF MEASUREMENT	Unit of cost (Kshs	**Total cost** (kshs
Stationary	Two reams of A4 papers	Paper ream	2 reams	600	1200
Pens pencils and erasers	Writing material	Biro pens Pencils Erasers	10 2 2	25 20 15	250 40 30
Proposal Development	Typing and printing	Proposal draft, 70 pages each	Proposal	500	500
Proposal printing	Printing	4 drafts 70 pages each	Drafts	400	1600
Photocopy charges	Photocopying	6 drafts each 70 pages	Draft	210	1260
Ethical Approval	KNH/UON Ethics	Proposal submission	Proposal	2000	2000
Data Collection and Analysis	Pretesting	Printing and photocopy	6 copies	250	1500
Interview guide guidelines and consent forms	Printing and photocopy	40 copies 4 pages each	Copy of guideline and consent form	3	500
Data collection	Research assistant	2 weeks (5 days per week) for 10 days	Per day	1000	1000
Data analysis	Statistician Software (NVivo 11)	Package	Data entry and analysis	60000	60000
Report	Draft report	Typing, printing and photocopy	150 pages, 1 copy 4 copies	@10 @750 @450	1750 500 1800
Participants airtime	45 min airtime	Per respondent	15participants	500	7500
Final report	Correction and printing	150 pages	Final report	5	750
Photocopying	Photocopying	7copies	Document copy	450	3150

Binding	Binding	7copies	Document copy	300	2100
Dissemination	Dissemination	Typing and printing	20 pages	15	300
Photocopying	Photocopying dissemination report	50 copies x 20 pages	Copy	60	3000
Binding	Binding	10 copies	Copy	50	500
Publishing of research	Publishing	Publishing	Copy	20000	20000
Subtotal					111,230
Contingencies (10%)					11,091
Grand total					122,321

Appendix III: Letter to Ethics and Research Committee

Josphine Wambui Ndirangu,

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Nairobi.

April 2021.

The Chairperson,

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P.O Box 20723-00202,

Nairobi.

REF: AUTHORITY TO CONDUCT A RESEARCH AT KENYATTA NATIONAL HOSPITAL CRITICAL CARE UNIT

I hereby seek your approval to carry out a research study on Nurses' Multicultural Transactions with Patients' Kins and its Impact on Quality Care. I am a postgraduate student at University of Nairobi undertaking a Masters Degree in Nursing Sciences (Critical Care). Attached, please find a copy of my research proposal duly signed by my supervisor and for your expert review and subsequent approval.

Thank you in advance.

Yours Faithfully,

Josphine Wambui Ndirangu.

Appendix IV: Letter to the Head of Critical Care Unit, Kenyatta National Hospital

Josphine Wambui Ndirangu

University of Nairobi,

P.O BOX 2229-00202

Nairobi.

April 2021.

The HoD,

Critical Care Unit,

Kenyatta National Hospital,

P.O Box 20723-00202

Nairobi.

REF: AUTHORITY TO CARRY OUT RESEARCH IN YOUR DEPARTMENT

I hereby seek your approval to carry out a research study on Nurses' Multicultural Transactions with Patients' Kins and its Impact on Quality Care. I am a postgraduate student at University of Nairobi undertaking a Masters Degree in Nursing Sciences (Critical Care). Attached, please find a copy of approval letter from ERC KNH/UoN

Thank you in advance.

Yours Faithfully,

Josphine Wambui Ndirangu.

Appendix 3: PARTICIPANT INFORMATION AND CONSENT FORM FOR ENROLLMENT IN THE STUDY

Title of Study: **Nurses Multicultural Transactions with Critically Ill Patients' Kins and Its Impact on Quality of Care in Kenyatta National Hospital Critical Care Unit**

Principal Investigator\and: **Josphine Wambui Ndirangu**

Institution: **School of Nursing Sciences University of Nairobi**

Introduction:

I would like to tell you about the study I am going to conduct. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be a participant in the study. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When I have answered all your questions to your satisfaction, you may decide to be in the study or not. This process is called 'informed consent'. Once you understand and agree to be in the study, I will request you to sign your name on this form. You should understand the general principles which apply to all participants in a medical research:

i. Your decision to participate is entirely voluntary
ii. You may withdraw from the study at any time without necessarily giving a reason for your withdrawal
iii. Refusal to participate in the research will not attract any penalty.
iv. You are free not to answer any question during the interview.

I will give you a copy of this form for your records.

May I continue? YES NO

This study has approval by The Kenyatta National Hospital-University of Nairobi Ethics and Research Committee protocol No. **P411/05/2021**

WHAT IS THIS STUDY ABOUT?

The researcher listed above is interviewing individuals who are Critical Care Nurses and have worked in CCU for more than two years. The purpose of the interview is to find out Nurses **Multicultural Transactions with Critically ill Patients' Kins and its Impact on Quality of Care** . Participants in this research study will be asked questions about cultural competence in multicultural transaction, specific aspects that impact on quality of care and challenges faced during the transaction. The number of participants in this study will not be predetermined but

will be determined by information saturation that is when no further new information is being obtained. I am asking for your consent to consider participating in this study.

WHAT WILL HAPPEN IF YOU DECIDE TO BE IN THIS RESEARCH STUDY?

If you agree to participate in this study, the following things will happen: I will conduct a virtual interview at your convenient time and bundles used for the interview will be refunded.. The interview will last approximately thirty (30) to forty five (45) minutes. The interview will cover topics such as different cultural norms, nurses cultural competence, culture interference with quality of care and challenges faced. I will ask for a telephone number that I can contact you if necessary. If you agree to provide your contact information, it will not be shared with any other person. The reasons why we may need to contact you include information clarification, if you are referred to the counselor for follow up and also for refund of interview bundles.

ARE THERE ANY RISKS, HARMS DISCOMFORTS ASSOCIATED WITH THIS STUDY?

Medical research has the potential to introduce psychological, social, emotional and physical risks. Effort will be made to minimize the risks. One potential risk of being in the study is loss of privacy. The researcher will keep everything you say as confidential as possible. A code number will be used to identify you in a password-protected computer database and all paper records will be kept in a locked file cabinet. However, no system of protecting your confidentiality can be absolutely secure, so it is still possible that someone could find out you were in this study and could find out information about you. Also, answering questions in the interview may be uncomfortable for you. If there are any questions you do not want to answer, you can express yourself. You have the right to refuse the interview or any questions asked during the interview. Also, some questions may be stressful (e.g. event recalls).

ARE THERE ANY BENEFITS BEING IN THIS STUDY?

The benefits of this research will help improve your communication and working together with multicultural kins and improve quality of care given to the patient. This information will also add into the body of knowledge that you can refer to in future.

WILL BEING IN THIS STUDY COST YOU ANYTHING?

Being in this study will not cost you anything and it will be done at your convenience and when you are comfortable.

WILL YOU GET REFUND FOR ANY MONEY SPENT AS PART OF THIS STUDY?

A refund of data bundles that will be used in the virtual interview will be refunded not exceeding five hundred Kenya shillings (500).

WHAT IF YOU HAVE QUESTIONS IN FUTURE?

If you have further questions or concerns about participating in this study, please call or send a text message to the researcher at the number provided at the bottom of this page. For more information about your rights as a research participant you may contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee Telephone No. 2726300 Ext. 44102 email uonknh_erc@uonbi.ac.ke. The researcher will pay you back for your charges if the call is for study-related communication.

WHAT ARE YOUR OTHER CHOICES?

Your decision to participate in research is voluntary. You are free to decline participation in the study and you can withdraw from the study at any time without injustice or loss of any benefits.

Josphine Wambui Ndirangu

Mobile No: 0721988898

School of Nursing Sciences

University of Nairobi

P.O Box 2229, Nairobi

email – ndiranguj@students,uonbi.ac.ke

Or

Dr. Lilian Omondi

School of Nursing Sciences

University of Nairobi

P.O BOX 30197, Nairobi.

Mob +2540720861317

Office email – laomondi@uonbi.ac.ke

Or

Dr. Dorcas Maina

School of Nursing Sciences,

University of Nairobi

P.O.BOX 30197, Nairobi.

Mobile 0724440843

Office email – mainad@uonbi.ac.ke

Or

The Chairman

KNH-UoN Ethics and Research Committee

P.O Box 20723, Nairobi.

Tel: 2726300 ext 44102, email uonknh_erc@uonbi.ac.ke

Appendix 4: **CONSENT FORM (STATEMENT OF CONSENT)**

Participant's statement

I have read this consent form and I have had the chance to discuss this research study with the researche. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study. I understand that all efforts will be made to keep information regarding my personal identity confidential.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study: Yes No

I agree to provide contact information for follow-up: Yes No

Participant printed name: _____

Participant signature / Thumb stamp _____ Date _____

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given his/her consent. Researcher's Name: _____ Date: _____

Signature

_____

Role in the study: study staff who explained informed consent form.

Appendix V: Interview guide

Serial no.....

Study Title: Nurses' Multicultural Transactions with Patients' Kins and its Impact on Quality Care: A Study in Kenyatta National Hospital Critical Care Unit

Introduction

Greetings! My name is (……..) and I will be facilitating this in-depth interview. Thank you so much for accepting to be part of this study. This interview intends to determine **Nurses' Multicultural Transactions with critically ill Patients' Kins and its Impact on Quality of Care**. This information will be anonymzed and will be confidential. You may withdraw at any time during the interview if you feel uncomfortable answering questions. The interview will be recorded for further analysis later and notes will also be taken during interview. All recordings and notes taken will be kept safely. (Confirm that the participant consent on recording before proceeding, if not interview will be terminated).The interview will take about 30-45 minutes.

Before we begin do you have any question?

Section A: **Biodemographic Data**

1. Gender…….
2. Age ……
3. Marital Status……
4. Religion…….
5. Highest level of education…….
6. Professional qualification: ……
7. Position Cadre… ……..
8. Years of working experience…….

A Probing Questions

9. Tell me in your own words what you understand by the term culture.
10. What kinds of cultural or religious beliefs have you encountered in CCU?
11. How does your own culture influence the care of a critically ill patient? Please explain
12. How do you integrate patient's culture into their care?
13. How would cultural competence training be important to nurses and how will it be of essence?

B probing Questions

14. How does patients'/kins culture impact on the quality of care given to the patient?

15. What kinds of culture do you consider beneficial to patient care and which one needs amending to benefit the critically ill patient?

C Probing questions

16. What challenges do you encounter in multicultural transactions?

17. How do you deal with these challenges?

18. What role does the institution play in the challenges faced?

Exit question.

19. Anything else you would want to add on multicultural transactions

Appendix VI: Similarity

Report

NURSES' MULTICULTURAL TRANSACTIONS WITH CRITICALLY ILL PATIENTS' KINS AND ITS' IMPACT ON QUALITY OF CARE: A STUDY AT KENYATTA NATIONAL HOSPITAL CRITICAL CARE UNIT

ORIGINALITY REPORT

9%	9%	1%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	erepository.uonbi.ac.ke:8080 Internet Source	4%
2	mafiadoc.com Internet Source	1%
3	www.tcd.ie Internet Source	1%
4	clinmedjournals.org Internet Source	1%
5	www.theseus.fi Internet Source	1%
6	file.scirp.org Internet Source	1%
7	Erepository.uonbi.ac.ke Internet Source	1%
8	link.springer.com Internet Source	1%

Supervisor 29/11/2021.

UNIVERSITY OF NAIROBI
FACULTY OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
Tel:(254-020) 2726300 Ext 44355

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Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/392

26th October, 2021

Josephine Wambui Ndirangu
Reg.No.H56/34258/2019
Dept. of Nursing Sciences
Faculty of Health Sciences
University of Nairobi

Dear Josephine

RESEARCH PROPOSAL: NURSES' MULTICULTURAL TRANSACTIONS WITH CRITICALLY ILL PATIENTS' KINS AND ITS' IMPACT ON QUALITY OF CARE; A STUDY AT KENYATTA NATIONAL HOSPITAL CRITICAL CARE UNIT (P411/05/2021)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH-UoN ERC) has reviewed and **approved** your above research proposal. The approval period is 26th October 2021 – 25th October 2022.

This approval is subject to compliance with the following requirements:

i. Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
ii. All changes (amendments, deviations, violations etc.) are submitted for review and approval by KNH-UoN ERC before implementation.
iii. Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
v. Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (Attach a comprehensive progress report to support the renewal).
vii. Submission of an executive summary report within 90 days upon completion of the study.

This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

Appendix 6: Map of Study Area