

Capturing Culturally Safe Nursing Care

by

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## ABSTRACT

This thesis represents a two phase, qualitative study using both Expert Review Panel and Delphi Panel research methods. The two research questions guiding this study were: 1) Phase I: What does culturally safe nursing practice mean, and how do we know when it is being practiced; and 2) Phase II: Can proposed culturally safe nursing practices be coded through use of International Classification for Nursing Practice (ICNP®) and/or Nursing Intervention Classification (NIC)?

Originating from the field of nursing in New Zealand, there is interest in adopting cultural safety in Canada to support culturally safe nursing care for Canada's Indigenous people (Canadian Nurses Association, 2009). A synthesis of the literature was conducted in Phase I of this study revealing six hallmarks of culturally safe nursing care. Those are: 1) *Creating trust*; 2) *Relinquishing power over relationships*; 3) *Approaching people with respect*; 4) *Seeking permission*; 5) *Listening with your heart and ears*; and 6) *Attending to those who's beliefs and practices differ*. Representing culturally safe care of an Indigenous elder, a case scenario, developed by the principle investigator (PI), was presented to cultural safety experts ( $n=3$ ) participating on an Expert Review Panel (ERP). The results of ERP showed that all six culturally safe nursing practices were represented in the case scenario. Validating that culturally safe nursing practices could be succinctly defined contributes to new knowledge, and most importantly informs nurses how to practice in a culturally safe nursing way.

The purpose of using a Delphi panel method in Phase II was to see if culturally safe nursing practices in the case scenario could be represented in the ICNP® and NIC

nursing languages by experts in those particular languages. To explore this two groups of subject matter experts in ICNP® ( $n=3$ ) and NIC ( $n = 3$ ) were invited to participate in separate Delphi panels. Overall, the Phase II Delphi panel results reflected the divergent way ICNP® and NIC are structured, in that terms alone do not provide enough contextual meaning to support clinical practice. The results of the ICNP® Delphi Panel showed that one ICNP® nursing intervention could represent culturally safe nursing care: *Establishing Trust*. Otherwise, the abstract composition of ICNP® terms affected the study results. The NIC Delphi panel results reflect the content and structure of NIC, and as such the experts identified the following four NIC nursing interventions that reflect culturally safe nursing care, they are: 1) *Culture Brokerage*, 2) *Complex Relationship Building*, 3) *Emotional Support*, and 4) *Active Listening*. Succinctly defining what nurses do is important; therefore, nursing languages need to be unambiguous, contextual so they are accurately and consistently documented. Validating culturally safe nursing practices exist—and further ensuring they are represented in standardized nursing languages and terminology sets and thus coded for use in an electronic health record (EHR)—ensures that culturally safe nursing care data is captured in the EHR.

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I would also like to thank my fellow students in the 2011-2017 NUHI cohort. Amongst them Kristie and Al; from the orientation session when we collectively drifted to the back of the room and with wild colored felt pens *mind mapped* what we thought our graduate school journey would look like; to the many day long Skype sessions where all that could be heard were the furious strikes on the keyboard, to this day—I feel like I gained two fine friends. Finally, to my many gal pals....I AM DONE....let's go ride our bikes, swim in the lake, and run the trails of the Okanagan, and beyond!

DEDICATION

I dedicate this thesis to my Mom and Dad, Shirley and Bill Lewis, both of whom I lost during this journey. Wherever you are in the realm of the infinite...thank you for teaching me to always be open minded; seize every moment that this life has to offer; and that love IS the way! I was so lucky to be your daughter—I love and miss you every day.

## CHAPTER 1

### INTRODUCTION

Cultural Safety is based in a postmodern, transformed and multilayered meaning of culture as diffuse and individually subjective. It is concerned with power and resources, including information, its distribution in societies and the outcomes of information management. (Ramsden, 2002, p. 12)

#### **Phase I: Describing Culturally Safe Nursing Practice**

##### **New Zealand's Influence on Cultural Safety in Canada's Nursing Education**

Cultural safety concepts originated in the discipline of nursing approximately thirty years ago in New Zealand. At that time, Maori nurses insisted that their nursing counterparts undergo a process of self-examination as a *call to action* in response to the disparate health status of New Zealand's Indigenous peoples (Ramsden, 1996). Cultural safety nursing courses were then developed. The cultural safety courses reflected that process of self-examination as one step towards culturally safe nursing practice. Changes to nursing curricula soon followed. As such, since 1992, nursing graduates in New Zealand have followed culturally safe nursing practice guidelines while caring for Maori patients (Nursing Council of New Zealand, 2011). Currently in Canada, nursing schools are incorporating cultural safety into nursing curricula, and in doing so, are preparing nursing students to practice in this way. As in New Zealand, the focus of this initiative is to contribute to the remediation of the health disparities for Canada's Indigenous peoples. Accordingly, Aboriginal Nurses Association of Canada (ANAC), renamed in 2015 to Canadian Indigenous Nursing Association of Canada (CINA), with the support of

Canadian Association for Nursing Schools (CASN) and Canadian Nursing Association (CNA), have articulated their collective position on cultural safety by stating the following:

Cultural safety takes us beyond cultural awareness and the acknowledgement of difference. It surpasses cultural sensitivity, which recognizes the importance of respecting culture. Cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge, and attitudes of practitioners. (Aboriginal Nurses Association of Canada, 2009, p.1.)

Although cultural safety nursing courses are now part of the curriculum in Canada and many nurses are taking these courses, it is difficult to know whether nurses are performing culturally safe care. For this reason, Phase I of this research study was, in part, an inquiry to see if the gap could be closed between learning about cultural safety as a concept and identifying specific culturally safe nursing practices.

The development and integration of cultural safety into nursing education in New Zealand has transformed nursing's approach to, and relationships with, Maori people there. Canada seems to be following New Zealand's lead and discovering that culturally safe nursing practice may be one solution that supports nurses to have successful relationships with their Indigenous patients.

### **Phase I: Research Question and Rationale**

The research question for Phase I of this research study was, "What does culturally safe practice mean, and how do we know when it is being practiced?" Currently, it is difficult to know if nurses are performing culturally safe care, as culturally

safe nursing practices have not been identified. Identifying culturally safe practices (by conducting an extensive review of the literature) so that nurses can incorporate them into everyday practice was the first goal of this research study. An Expert Review Panel of cultural safety nursing experts was assembled to explore this possibility.

## **Phase II: Documenting Culturally Safe Nursing Practices**

### **Nursing Informatics and Standardized Nursing Languages and Terminology Sets**

Even though performing “hands on” nursing care continues to be the foundation of the nursing profession, Health Informatics (HI) and Nursing Informatics (NI) can also enhance patient care. Health Informatics is the study of digital health information systems and health data in general. While Nursing Informatics pertains to those aspects of health information systems and data related to nursing. Nursing Informatics is defined as, “the science and practice that integrates nursing, its information and knowledge, with management of information and communication technologies to promote the health of people, families, and communities worldwide” (American Medical Informatics Association, 2014, p. 1). While the efficient and timely collection, analysis, and aggregation of nursing data is important, advancing the science of NI, also increases the visibility of nursing contributions to patient care outcomes. As such, NI is the field that studies all aspects of nursing data, and the main objective of doing so, is to improve clinical care.

Organizations such as the Canadian Nurses Association, also highlight the importance of this field as exhibited in their recent NI position statement, which states that,

“...registered nurses and other stakeholders in the health care delivery

require information on nursing practice and its relationship to client outcomes. A coordinated system to collect, store and retrieve nursing data in Canada is essential for health human resource planning, and to expand knowledge on research on determinants of quality nursing care.... CNA believes that registered nurses should advocate and lead in implementing the collection, storage, and retrieval of nursing data at the national level” (Canadian Nurses Association, 2015, para. 3).

Although only formalized in recent years in statements such as the above, the profession of nursing has long contributed to nursing informatics (Saba & Westra, 2016). In fact, evidence suggests that the original ideas pertaining to the field of NI date as far back as Florence Nightingale.

Florence Nightingale was interested in standardizing nursing activities as far back as 1859 (Whittenburg & Saba, 2016). At the time, Nightingale’s objective was to standardize nursing education, in turn ensuring uniform nursing practices and, thus, uniform patient outcomes. Although nursing data can now link standardized care to patient outcomes, at the time, Nightingale had already grasped that linking practice to patient outcomes requires that nursing practices be succinctly described, communicated, and documented. By succinctly describing and documenting nursing practices, Nightingale found that nursing care could be compared across patients and populations. Much later in the 1970’s, developments such as the widely known “Nursing Process,” further structured nursing activities into the following categories: Assessment, Diagnosis, Planning, Implementation, and Evaluation (Häyrinen, Lammintakanen, & Saranto, 2010; Schaefer, 2010a). Nightingale’s early work to standardize nursing education and nursing

practices, and later the development of the nursing process helped build the foundation for what is now known as standardized nursing languages (SNL) and terminology sets (Häyrinen, Lammintakanen, & Saranto, 2010; Whittenburg & Saba, 2015).

In the past three decades, SNL and terminology sets were developed to describe nursing diagnosis, actions, and outcomes by standardizing related concepts and terms. Once nursing actions are compiled into lists in SNL and terminology sets they are then referred to as nursing *interventions* (Jones, Lunney, Keenan, & Moorhead, 2011; Schwirian, 2013; Whittenburg & Saba, 2015). Nursing interventions are the focus of this study. Overall, SNL and terminology sets are a substantive component of NI and as such increase the visibility of nursing interventions in what is known as the Electronic Health Record (EHR).

### **Nursing Interventions and the Electronic Health Record**

Modern nurses have been formally providing care and, therefore, affecting patient outcomes for well over a century. For the most part, this contribution has been recorded in a paper-based record, called a *patient chart*. As such, *the patient chart* has been known as the primary source for communicating nursing care between nurses and to others on the patient's health care team. While this method has served to record and communicate nursing care in the past, electronic records offer a better way to document and relay information between nurses and other health care teams.

As an electronic version of a paper patient chart, the EHR is a longitudinal record of health-related data, including test results, specialist consultative reports, as well as admission and discharge information, for every patient in the hospital (Shabestari & Roudsari, 2013). While managing health information is important, the EHR also

provides a digital platform for documenting nursing interventions. Tracking and analyzing nursing interventions in the EHR using these SNLs and terminology sets can signify the effect of nursing care on patient outcomes. Therefore, the EHR serves, amongst other purposes, as a repository of nursing data.

### **Phase II: Research Question and Rationale**

The research question for Phase II of this research study was, “Can proposed culturally safe nursing practices be coded through use of International Classification of Nursing Practice (ICNP®) and/or Nursing Intervention Classification (NIC)?” The ICNP® is a terminology set, and the NIC is a standardized nursing language. Therefore, both ICNP® and NIC were applicable systems to explore and see if they already represented nursing interventions that reflected culturally safe practices. Two Delphi panels were launched in 2015. One Delphi panel consisted of ICNP® subject matter experts and another of experts from NIC.

### **Thesis Organization**

This thesis consists of 8 Chapters and is organized as the study proceeded, that is Phase I followed by Phase II. Subsequent to Chapter 1, Chapters, 2, 3, 4, and 5 pertain to Phase I of this study. Chapter 2 presents the cultural safety literature search, review and synthesis. In Chapter 3 the research instrument (case scenario) along with an explanation of the six culturally safe nursing hallmarks is presented. While Chapters 4, and 5, detail the Expert Review Panel method and findings, respectively. Phase II of this study is introduced in Chapter 6 when the Delphi Panel Method is discussed. Chapter 7 presents the results of the ICNP® and NIC Delphi panels. Chapter 8 then discusses the findings of

Phase I and Phase II, along with recommendations for future research, limitations of this research study, and conclusions.

## CHAPTER 2

### LITERATURE REVIEW

This study focused on describing and documenting culturally safe nursing interventions. The purpose of a literature review is to understand current knowledge about a certain subject. In the case of this study, the subject of inquiry is cultural safety. For this reason, the focus of this literature review was to gain a better understanding about cultural safety. The literature review method and results are described in this chapter.

#### **Literature Review Method**

The literature search conducted for this study on the topic of cultural safety in Canada was initiated in June 2014. Academic and grey literature (including government, professional, and international sources) references were added until July 2016. The inclusion criteria for the literature search were a combination of the following key terms: a) cultural safety, a) nursing, and c) Canada. The exclusion criteria for the articles were; a) cultural safety and physician practice, b) culturally safe practices in allied health fields, c) transcultural nursing and cultural safety, and d) cultural competency references.

A primary search of CINAHL (Cumulative Index of Nursing and Allied Health Literature) using the search string “cultural AND safety AND nursing” returned 360 publications. Narrowing the search further using the search string “Cultural” AND “Safety” AND “Nursing” AND “Canada” resulted in 24 articles found. Once reviewed, 18 were relevant to the study’s focus on cultural safety in nursing in Canada. Six articles were excluded because they focused on Transcultural nursing and cultural competencies

rather than culturally safe nursing. The included articles had a primary focus on cultural safety and nursing in Canada, although they may have referenced cultural safety in New Zealand or Australia. The specific search strategies using different configurations of the above key words are presented in tables below showing, first, the CINAHL search results (see Table 1).

Table 1

*University of Victoria Online Library: Database: CINAHL*

Terms	Results	Excluded	Selected
Cultural AND Safety AND Nursing AND Canada	24	6	18

A secondary search (Table 2) of both “Web of Science” and “Science Direct” databases using the term “Culturally Safe Nursing Practices in Canada” resulted in many (283) articles. Upon reviewing article titles and, in some cases, their abstracts, it was noted that articles are sorted by relevance; therefore, many references were noted to not pertain to nursing as the review advanced. Some discarded references were found to be duplicates from the previous CINAHL search. Other discarded references mentioned mental health or other allied health domains, sources that referred to cultural competencies, and sources pertaining to other ethnic groups. Ten remaining references met the inclusion criteria and, therefore, were included in the literature review.

Table 1

*University of Victoria Online Library: Databases: Web of Science, Science Direct*

Terms	Results	Excluded	Selected
“Culturally Safe Nursing Practices in Canada”	283	273	10

A third search of Google Scholar (Table 3) revealed a significant number of articles referencing cultural safety. The key terms used in the Google Scholar search were “Cultural Safety” and “Aboriginal peoples,” revealing many ( $n=48,595$ ) references. Since Google Scholar presents search results by relevance, the first eight pages representing 64 articles were reviewed. Rejected articles were in the following categories: duplicates, transcultural nursing information, physician cultural safety training, allied health references, and articles using terms other than those identified in the inclusion criteria (such as culturally appropriate care, cultural humility, and cross-cultural care). Two new papers were found to be relevant to cultural safety and Indigenous peoples in nursing in Canada.

Table 2

*University of Victoria Online Library: Search Engine: Google Scholar*

Terms	Results	Reviewed	Excluded	Selected
“Cultural Safety” and Aboriginal Peoples	48, 595	64	62	2

A total of three websites were searched: the Aboriginal Nurses Association of Canada (Aboriginal Nurse Association of Canada, 2009, p.1) and the Canadian Nurses Association (Canadian Nurses Association, 2015, para. 4), both included relevant information on cultural safety nursing for Canada’s Indigenous peoples. Among other materials that were relevant to this study, one position statement is mentioned in Chapter 1 of this research report. A third source, the Nursing Council of New Zealand (NCNZ) website was also reviewed for relevant materials because New Zealand is referred to as the birthplace of cultural safety. Culturally safe definitions, guidelines, and competencies

included on the Nursing Council of New Zealand website informed this study's literature review.

A further six references were then added to the reference list. Obtained from a personal library, the six additional sources met both the inclusion and exclusion criteria. Among the added references categorized as grey literature were nursing course syllabi and culturally safe practice-based materials. Adding these six materials resulted in thirty-eight references (see Appendix B).

### **Literature Overview**

Cultural safety is an emerging field of interest in Canada. Most of the pertinent literature has reported qualitative research or presented the development and meaning of the concept of cultural safety; there was very little quantitative and no controlled trial research represented in the literature. Several academic articles and grey literature also described the history of cultural safety. As well, Canadian nursing organizations and academic institutions have shown an interest in the practice of cultural safety as it is first described, in references from New Zealand (Browne, Smye, & Varcoe, 2005; Mahara, Duncan, Whyte, & Brown, 2011; Smye & Browne 2002; Canadian Nurses Association, 2009).

### **The Influence of New Zealand's Cultural Safety on Canada**

In the mid-1980s, a nurse named Irihapeti Ramsden founded the culturally safe practice movement in her home country of New Zealand. Ramsden's early work was influenced by international Indigenous theorists of the time (Ellison-Loschmann, 2003). According to Ramsden (2002), the overall aim of cultural safety was to educate nurses

to be more aware of their own cultural and societal origins and the resulting effects of these on their nursing practices.

Cultural safety nursing and midwifery curricula were developed in New Zealand in the 1980s as a call to remedy the prevailing colonial notion of *biculturalism* (Papps, 2005). Although a key concept related to cultural safety, at the time, the term *biculturalism* was laden with white settler social dominance and characterized by a negative stereotype of Maori people (Papps & Ramsden, 1996; Ramsden, 2002). More recent literature has reflected a change in the meaning of *biculturalism* to one that acknowledges the cultural differences between a non-Maori nurse and a Maori patient (Blackman, 2009; Jacklin, 2009; Papps, 2005).

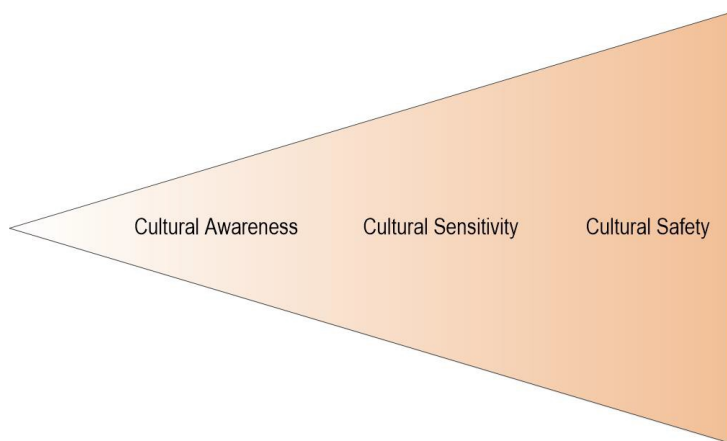
Nurse educators in New Zealand developed culturally safe curricula and competencies. The goal of culturally safe nursing curricula, guidelines, and competencies were to transform nursing attitudes and practices in support of bicultural interactions with Maori patients (Mahara, Duncan, Whyte, & Browne, 2011; Papps, 2005; Polaschek, 1996). Culturally safe competencies then became a baccalaureate requirement for nursing and midwifery graduation in New Zealand, guiding nurses and midwives into partnerships with Maori patients (Ramsden, 2002).

Despite challenges from both academic and political organizations over the past forty years, the central concept of cultural safety—that of *transferring power from nurse to patients*—has remained constant. Peripheral arguments regarding the applicability of cultural safety to other populations have been noted throughout the literature (Mortensen, 2010; Polaschek, 1998). Others have proposed that cultural safety should have been located in such frameworks as post colonialism or critical social theory (Browne, Smye,

& Varcoe, 2005; Hall, 1999; McConaghy 1997; Ramsden, 2002; Reimer-Kirkham, Lynam, & Wong, 2009; Smylie, Kaplan-Nyrth, & McShane, 2009). However, leading authors contended that cultural safety was unique because it was created by nurses for nurses and, therefore, should stay in the nursing domain (Papps, 2005; Ramsden, 2002).

### **Cultural Safety**

The literature reviewed for this study described culturally safe nursing practice as an acquired *way of being*. This *way of being* is achieved by progressing from cultural awareness through cultural sensitivity to culturally safe nursing practice. Figure 1 represents the progression of steps that nurses take towards culturally safe nursing practice. This progression starts with a nurse's internal awareness then moves through a process towards power-balanced relationships with patients. Power balanced relationships between nurses and their patients represent culturally safe nursing.



*Figure 1.* Progression to culturally safe nursing practice.

### **Cultural Awareness**

Exploring the first step towards culturally safe nursing practice—that of cultural awareness—focused on the observations of people who are culturally different. Observing a patient's activities, and how they choose to proceed towards their own definition of health, were noted to be key to being culturally aware. New nurses engaging in cultural awareness might imagine themselves in the position of their patients or have listened to their patients without interrupting (Papps, 2005). Nurses who increased their level of cultural awareness as a fundamental first step would have been focused mainly on external observation (Brascoupé & Waters, 2009; Papps, 2005; Ramsden, 2002). Developing an understanding of the significance of culture, and noting that culture is diverse and unique, was also critical for a new nurse becoming culturally aware.

### **Cultural Sensitivity**

According to the literature, it was noted that, as nurses moved closer to culturally safe practice, developing culturally sensitivity was imperative. As step 2, cultural sensitivity was characterized by an acknowledgement by the nurse of cultural difference—*biculturalism* (Browne, Smye, & Varcoe, 2005; Dyck & Kearns, 1995; Polaschek, 1998). Awareness of a bicultural interaction served as a cue for the nurse to begin an internal process of self-exploration of personal racial biases (Spence, 2005). For a nurse, becoming aware of these influences might bring to the surface tensions or oppressive beliefs and assumptions (Brascoupé & Waters, 2009; Papps, 2005, Ramsden, 2002; Spence 2005). Tracing the origins of pre-existing prejudices, racial stereotyping, or biases was reported to create an opportunity for a nurse to self-reflect (Papps, 2005; Ramsden 1996, Ramsden, 2002). Internal transformation was noted to be possible for

nurses, if they self-reflect and dismantled racist biases (Ramsden, 2002). Therefore, cultural sensitivity builds on cultural awareness by nurse's examining and changing their own worldview, versus observing how patients express their culture.

### **Cultural Safety**

Cultural safety nursing guidelines verify that patient self-determination is key when providing culturally safe nursing care. Conceptualized as an outcome of self-determination, the assertion of safety in this instance can only be confirmed by the recipient of care (Papps, 2005). Culturally safe practice is possible when nurses step beyond their external awareness and internal learning to take this last step. This means that, when a nurse acknowledges the *patient as expert*, culturally safe nursing practice is possible. Culturally safe nursing practice, as Blackman (2009) has reminded us, "heavily depends on a number of factors such as a nurse's readiness to be culturally safe, ability to listen and communicate appropriately" (p. 213). MacDonald (2005) agreed and further stated that there is no "recipe book approach" for this last step towards culturally safe nursing practice to be successful. However, nurses who provide culturally safe care prioritize the patient's knowledge of self when planning care (Ramsden, 2002).

### **Cultural Safety in Canadian Literature**

Cultural safety is being incorporated into nursing education and health care organizations in Canada. In fact, a culturally safe health care delivery system was proposed to contribute to resilient Indigenous communities and individuals (Brascoupé & Waters, 2009). However, more research is needed to develop culturally safe nursing practice and health policy (Brascoupé & Waters, 2009; Browne, Smye, & Varcoe, 2005;

Jacklin, 2009; Smye & Browne 2002). In the literature, no succinct, culturally safe nursing practices were described.

### **Common Ideas Found in Culturally Safe Literature**

A first examination of the literature set revealed that there were recurring ideas that could describe culturally safe nursing practices. Upon a second review of the literature set, those common ideas were highlighted and color-coded. A third examination was undertaken to identify each common idea and to write each idea into the margins of the paper being reviewed. It was then observed that there were six repeated ideas. A fourth review of the literature revealed that each of the six common ideas was repeated in no less than seven different articles. The fourth review of the literature also revealed that no one article contained all six ideas.

In order to further understand commonalities (a fifth review), the surrounding text was investigated to ensure that there was a common meaning behind each of the repeated ideas. Over the course of five reviews, it was determined that the repeated ideas and surrounding text were common in 32 of the 38 articles. Common ideas found in the culturally safe literature were as follows:

1. Creating trust,
2. Relinquishing power over relationships,
3. Approaching people with respect,
4. Listening with both your heart and your ears,
5. Seeking permission, and
6. Attending to the beliefs and practices of those who differ.

Each common idea and the articles in which the idea is discussed are presented in detail in Table 4, followed by a synopsis of the six hallmarks of culturally safe nursing practices.

Table 3

*Hallmarks of Cultural Safety and Associated References*

Hallmarks of Cultural Safety Nursing	References
1. Creating Trust	Ball, 2007; Blackman, 2009; Brascoupé & Waters 2009; Browne, Smye & Varcoe, 2005; Hartrick Doane & Varcoe, 2005; Mahara, Duncan, Whyte, & Browne, 2011; Papps, 2005; Ramsden, 2002.
2. Relinquishing power over relationships	Blackman, 2009; Charter, 1997; Bidzinski, Boustead, Gleave, Russo, & Scott, 2012; Bishop, 2002; Kelly & Peekekoot, 2005; Northrup, 2005; Papps, 2005; Papps & Ramsden 1996; Ramsden, 2002; Smye & Browne, 2002; Tang & Browne, 2008; Wepa, 2004.
3. Approaching people with respect	Bidzinski, Boustead, Gleave, Russo & Scott, 2012; Bishop, 2002; Blackman, 2009; Jacklin, 2009; Little Bear, 2000; MacDonald, 2005; Othmar & Bruce, 2005; Papps, 2005; NAHO, 2003; Papps, 2005; Polaschek, 1998; Ramsden, 2002; Spence, 2005.
4. Listening with both your heart and ears	Bidzinski, Boustead, Gleave, Russo & Scott, 2012; Hartrick Doane & Varcoe, 2006; Bishop, 2002; Blackman, 2009; Little Bear, 2000; Othmar & Bruce, 2005; Papps, 2005; Ramsden, 2002.
5. Seeking permission	Bidzinski, Boustead, Gleave, Russo, & Scott, 2012; Brascoupé & Waters, 2009; Blackman, 2009; Hartrick Doane & Varcoe, 2006; Papps, 2005; Ramsden, 1997; Ramsden, 2002.
6. Attending to the beliefs and practices of those who differ	Blackman, 2009; Browne, Varcoe, Smye, Reimer-Kirkham, Lynam & Wong, 2009, Hartrick Doane, & Varcoe, 2006; New Zealand International Council of Nurses, 2004; Ramsden, 2002; Spence, 2005; Smye & Varcoe, 2002.

## **Hallmarks of Culturally Safe Nursing References and Rationale**

### **1. Creating Trust**

Many references mentioned the concept of trust in the cultural safety literature. Trust was noted to be an imperative component for nurses to create and maintain successful bicultural relationships with patients. Trust was also noted to influence the success of all future patient interactions (Browne, Smye, & Varcoe, 2005; Hartrick Doane & Varcoe, 2005; Ramsden, 2002). Although no decisive definition of trust was located, several common elements enabling trust were found. Examples of trust enablers included: sharing personal information, humor, and touch (Blackman, 2009; Hartrick Doane & Varcoe, 2005). Authors also proposed that creating trust requires a nurse to attend to both verbal and non-verbal cues in order to initiate and maintain culturally safe nurse patient relationships (Blackman, 2009; Brascoupé & Waters, 2009; Mahara, Duncan, Whyte, & Browne, 2011; Papps, 2005; Ramsden, 2002). Creating nurse-patient partnerships helps to initiate trusting relationships between nurses and patients. The demonstration of a patient's confidence in his or her own health choices is a hallmark of trust within the nurse-patient relationship (Hartrick Doane & Varcoe, 2005; Papps, 2005; Ramsden, 2002). Overall, creating trust is said to be critical for the development of bicultural relationships (Ball, 2007; Browne, Smye, & Varcoe, 2005; Papps, 2005).

### **2. Relinquishing Power Over Relationships**

Power was one of the most central concepts found in the cultural safety literature. A central tenet noted was patient self-determination, or the power of the patients to be the primary decision makers regarding their own care (Charter, 1997; Papps, 2005; Papps & Ramsden, 1996; Ramsden, 2002; Wepa, 2004). Existing social and health structures may

not support patient self-determination and may, instead, reinforce the authority of the health care provider as a decision maker (Kelly & Peekekoot, 2005; Northrup, 2005). This biomedical model of healthcare can hinder the development or maintenance of a shared power relationship between nurses and patients (Papps, 2005; Ramsden, 2002; Smye & Browne, 2002). Relinquishing nursing power in patient-provider relationships enables partnerships that promote health and healing (Blackman, 2009; Ramsden, 2002). Reallocation of power from the health care provider to the patient is often necessary to build a power-balanced relationship (Bidzinski, Boustead, Gleave, Russo, & Scott, 2012; Bishop, 2002; Tang & Browne, 2008).

### **3. Approaching People with Respect**

The guiding principles found throughout the literature identified respect for the cultural needs and values of patients as important (MacDonald, 2005; NAHO, 2003; Othmar & Bruce, 2005). Respecting patients, in this case, means that the nurse must acknowledge that each culture is unique and may define health differently (Jacklin, 2009). As further described in the literature, Indigenous peoples have many ways of defining health and, therefore, require varying pathways towards achieving health (Papps, 2005; Polaschek, 1998; Ramsden, 2002; Spence, 2005). Respecting different patient worldviews and how these views influence a self-determined path towards health, was noted to be critical to culturally safe nursing practice.

### **4. Listening with Both Your Heart and Ears**

Listening was a central theme in the cultural safety literature. Nurses were considered culturally safe when they noticed and attended to subtle patient cues (Hartrick Doane & Varcoe, 2005). In other words, it is important for a nurse to understand that a

patient's subtle actions may hold more importance than the words they speak. To do this successfully, nurses must listen with all of their senses and show interest both verbally and non-verbally (Bidzinski, Boustead, Gleave, & Rousso, 2009; Bishop, 2002; Blackman, 2009; Little Bear, 2000; Othmar & Bruce, 2005; Papps, 2005; Ramsden 2002).

### **5. Seeking Permission**

Permission should be elicited before nursing interventions proceed in a culturally safe nursing interaction (Brascoupé & Waters, 2009; Ramsden, 1997; Ramsden, 2002). Seeking permission before proceeding with nursing care illustrates a nurse's ability to self-assess before engaging in a bicultural interaction (Blackman, 2009; Hartrick Doane, & Varcoe, 2005). In doing so, nurses give patients a chance to choose when, and how, they want nursing services to be delivered (Ramsden, 2002). When nurses attend to patients and their diverse needs based on their cultural practices and beliefs, successful bicultural interactions can occur. When successful bicultural interactions occur, then culturally safe nursing practice can be achieved (Bidzinski, Boustead, Gleave, Russo, & Scott, 2012; Brascoupé & Waters, 2009; Papps, 2005; Ramsden, 2002).

### **6. Attending to the Beliefs and Practices of Those Who Differ**

The literature indicated that working in partnership with those who do not hold the same cultural identity is culturally safe nursing (Ramsden, 2002; Smye & Browne, 2002). Those who study cultural safety also indicated that nurses must demonstrate self-reflective practice. Self-reflective practice means that attention must be paid to an internal awareness that personal beliefs and assumptions affect nursing care (Blackman, 2009; Hartrick Doane, & Varcoe, 2006; International Council of Nurses, 2004). The

premise of attending to those who differ is further characterized by nurses, in the spirit of inquiry, offering services according to their patient's individual background and preferences (Browne et al., 2009; Ramsden, 2002; Reading & Wien, 2009; Spence, 2005).

### **Summary**

Several Canadian references noted in this literature review mention New Zealand, the birthplace of cultural safety. The progression toward reaching culturally safe nursing practice was described in the literature as a process that starts with cultural awareness then cultural sensitivity and onto cultural safety. At all times, culturally safe nursing practice requires both external observation and internal self-reflection and assessment.

After several iterative reviews of source materials, six common ideas and their contextual meanings were discovered. These six hallmarks of culturally safe nursing practices were then embedded in a nursing case scenario, developed by the PI and used in both phases of this research study.

## CHAPTER 3

### RESEARCH INSTRUMENT

The following case scenario was developed to illustrate the six culturally safe nursing hallmarks as described in the literature. As a research instrument, the case scenario was used as a means to explore expert opinion about culturally safe nursing practices. The rationale for using a case scenario was to have a vehicle to embed the hallmarks of culturally safe practices for review by subject matter experts. While the literature review revealed what it means to practice culturally safe nursing, the case scenario provides a vehicle to validate the culturally safe nursing practices. The first sample of the case scenario is the version as presented in this research (see Figure 2). The second example of the case scenario is a coded version showing the placements of each of the six culturally safe nursing interventions (see Figure 3). Following the coded version is a further explanation of culturally safe nursing interventions.

#### **Explanation of Embedded Culturally Safe Nursing Activities**

Below is a breakdown of how the themes were deliberately incorporated into the scenario. Each theme is color-coded and superscripts appear at the end of each highlighted sections to indicate the matching theme. Each section of pertinent text also has a superscript number for the relevant theme in addition to the color code:

1. Creating Trust = pink<sup>1</sup>,
2. Relinquishing power over relationships = red<sup>2</sup>,
3. Approaching people with respect = grey<sup>3</sup>,
4. Listening with both your heart and ears = teal<sup>4</sup>,
5. Seeking Permission = yellow<sup>5</sup>,
6. Attending to the beliefs and practices of those who differ = Green<sup>6</sup>.

Following morning report and a review of her charts, Abby walks into room #324 to find her assigned patient, John Charlie, sitting up in bed. Noting that John appears comfortable, Abby introduces herself, making eye contact: "I am your nurse for today," she states, and then asks permission to sit down in the chair beside the bed. While pulling the chair up beside the bed, Abby notices that although John initially made eye contact as he acknowledges her introduction, he soon looks away. Abby follows his cue, and does not attempt to hold his gaze.

Initiating further conversation by acknowledging what brought John into the hospital, Abby inquires, "I know you have had a hard couple of days and I am interested in what has happened to you." Abby reaches out to touch John's hand briefly at the same time she touches her own chest and nods her head as he describes what has happened. "This has been tough for you," Abby suggests, and that succeeds in eliciting more information from John. Continuing to follow his story, Abby nods her head, indicating that she is interested and attentive. She then inquires, "And how are you today?" Abby notes John sighs and laughs softly: "Well, I think I am on the mend now." and she nods her head and returns his tentative smile.

Standing up and approaching John's bed only when he has finished describing his current condition and the conversation has slowed, Abby asks, "Can I take your blood pressure would that be okay?" As John nods his head, Abby intentionally starts with the least invasive vital sign measurement first; she takes his blood pressure (130/28) then pulse (72 and regular) and notes, upon taking his temperature, he is afebrile. Throughout performing these interventions, Abby moves slowly, continuing to seek his permission throughout the procedure by saying, "Ok, now I will take your pulse and then temperature, is that okay as well?"

Looking for ways to continue to create trust as she is performing vital signs, Abby inquires, "Has your family been to visit?" Showing interest in his responses, she notes John becomes more engaged in conversation when he speaks of his family. Abby asks further questions like, "Where are you from?" Continuing to show interest while she is learning more about John's family, Abby also offers, "My family also lives close by." As Abby now senses even more ease in the conversation, she inquires, "Is there someone in your community that could come visit you such as your traditional healer? We have the Okanagan room that we could reserve for you if that might work?" When John responds with "I will think about that" Abby moves the conversation forward to ask when would be a good time to change John's abdominal surgical dressing. "John, can I come back after breakfast and change your dressing? I'd like to hear more about your family as well." When John responds "yes," Abby thanks him for the visit and confirms she will be back after breakfast.

*Figure 2. Culturally safe nursing case scenario.*

Following morning report and a review of her charts, Abby, walks into room #324 to find her assigned patient, John Charlie, sitting up in bed. Noting that John appears comfortable, Abby introduces herself, making eye contact: "I am your nurse for today" she states<sup>3</sup> and then asks permission to sit down in the chair beside the bed<sup>5</sup>. While pulling the chair up beside the bed, Abby notices that although John initially made eye contact as he acknowledges her introduction, he soon looks away. Abby follows his cue, and does not attempt to hold his gaze.<sup>6</sup>

Initiating further conversation by acknowledging what brought John into the hospital, Abby inquires, "I know you have had a hard couple of days and I am interested in what has happened to you".<sup>2</sup> Abby reaches out to touch John's hand briefly at the same time she touches her own chest and nods her head as he describes what has happened.<sup>4</sup> "This has been tough for you," Abby suggests, and that succeeds in eliciting more information from John.<sup>2</sup> Continuing to follow his story, Abby nods her head, indicating that she is interested and attentive. She then inquires, "And how are you today?" Abby notes John sighs and laughs softly, "Well I think I am on the mend now," and she nods her head and returns his tentative smile.<sup>4</sup>

Standing up and approaching John's bed only when he has finished describing his current condition and the conversation has slowed,<sup>3</sup> Abby asks, "Can I take your blood pressure would that be okay?"<sup>5</sup> As John nods his head, Abby intentionally starts with the least invasive vital sign measurement first; she takes his blood pressure (130/28) then pulse (72 and regular) and notes, upon taking his temperature, that he is afebrile.<sup>1</sup> Throughout performing these interventions, Abby moves slowly, continuing to seek his permission throughout the procedure by saying, "Ok now I will take your pulse and then temperature. Is that okay as well?"<sup>5</sup>

Looking for ways to continue to create trust as she is performing vital signs, Abby inquires, "Has your family been to visit?"<sup>1</sup> Showing interest in his responses, she notes that John becomes more engaged in conversation when he speaks of his family.<sup>4</sup> Abby asks further questions like, "Where are you from?" Continuing to show interest while she is learning more about John's family.<sup>2</sup> Abby also offers, "My family also lives close by."<sup>1</sup> As Abby now senses even more ease in the conversation,<sup>4</sup> she inquires, "Is there someone in your community that could come visit you such as your traditional healer? We have the Okanagan room that we could reserve for you if that might work."<sup>6</sup> When John responds with, "I will think about that," Abby moves the conversation forward to ask when would be a good time to change John's abdominal surgical dressing. "John, can I come back after breakfast and change your dressing?"<sup>5</sup> "I'd like to hear more about your family as well"<sup>6</sup> When John responds "yes," Abby thanks him for the visit and confirms she will be back after breakfast.<sup>3</sup>

Figure 3. Case scenario coded for culturally safe nursing interventions.

## **1. Creating Trust**

In the case scenario, creating trust is represented in four different instances. These examples are highlighted using the color pink. Creating trust is established and maintained by Abby using both verbal and non-verbal communication approaches. Specific strategies used by Abby for establishing and maintaining trust are: sharing personal information; showing interest in the patient's family; and nodding her head to show interest. Abby also starts taking vital signs with the least invasive measure first, again showing the subtle, intuitive, and complex nature of creating trust.

## **2. Relinquishing Power Over Relationships**

Abby relinquishes power (as noted in the color red) by being interested in engaging in a *person-to-person* relationship. Nurse Abby approached the patient and continued to converse in deference to the patient's self-knowledge in four instances. Important aspects of relinquishing power over relationships are shown in the case scenario. They include showing empathy, expressing interest in the patient and his family relationships, and consulting and planning care with the patient.

## **3. Approaching People with Respect**

The specific examples of approaching people with respect are coded in the color grey. The concept of respect, although color-coded twice, is also interwoven throughout the case scenario. A clear example of approaching people with respect in the case scenario include Abby introducing herself and concluding her interaction with a follow-up plan for care for the patient. Other examples of nursing with respect are interwoven into "relinquishing power over relationships" and "attending to the beliefs and practices

of those who differ.” Overall, nursing patients in a respectful manner is expressed in the case scenario by pacing the conversation according to client’s comfort level.

#### **4. Listening with Both Your Heart and Ears**

In the case scenario, the examples of listening in this way are highlighted in teal. Although there are three examples that were intentionally created, listening with both your heart and ears is interwoven throughout the case scenario. Illustrated in the case scenario, listening with both her heart and ears is found when Abby is displaying that she is paying attention by nodding her head and, at the same time, using touch to confirm this, responding in an attentive manner, and noticing when the conversation is easing. Listening with both heart and ears requires nurses to engage all their senses. Overall, listening with both your heart and ears is not a distinct action but an impression that is intuitively enacted by the nurse while in relationship with a patient.

#### **5. Seeking Permission**

In this scenario, Abby seeks permission from the patient at four different times. These examples are noted above in yellow. An important aspect of “seeking permission” is recognition that permission needs to be ongoing. This is represented in the scenario by multiple instances of Abby asking for permission for a variety of nursing tasks. A patient’s permission for an activity is specific to that time and that particular activity. Abby does not make the assumption that permission for sitting bedside is also permission for assessing vital signs. Permission is explicitly sought in the scenario for each nursing task. The time element is addressed in the last example, where Abby asks about returning at a future time for a dressing change.

## **6. Attending to the Beliefs and Practices of Those Who Differ**

Three examples occur in the case scenario that represent nurse Abby's attentiveness to the beliefs and practices of her patient, as she attends to her patient in this way. These examples are noted in the color green. Attending to the beliefs and practices of those who differ is evident when Abby follows the lead of her patient and adjusts her gaze, offers to coordinate time in the designated room at the hospital, queries whether the services of traditional healer might be wanted, and expresses a desire to know more about John's family.

### **Summary**

The case scenario was developed to represent a patient encounter with a First Nations elder. The case scenario, as written, includes physiological monitoring that is typical for nursing practice interwoven with more subtle nursing actions. Not all nursing activities are performed in isolation or one after another. Some nursing activities may overlap or be intertwined between conversations. These subtler ways of being represent culturally safe nursing practice. Cueing the reader to the six culturally safe nursing practices was attempted by creating an example of how they might be attained. For example, "creating trust" and "listening with both your heart and ears" are not mutually exclusive but may occur in conjunction with one another. In other words, "creating trust" and "listening with both your heart and ears" are not two distinct actions but rely on pacing, timing, and the nurse's ability to self-assess and reflect.

## CHAPTER 4

### PHASE I: RESEARCH METHODS

#### **Research Question**

This chapter describes the research methods used in Phase I of this study. The selection of a Phase I research method was guided by the following research question: “What does culturally safe nursing practice mean and how do we know when it is being practiced?” The literature described six hallmarks of culturally safe nursing care that were then embedded in a case scenario and proposed, for validation purposes, to an Expert Review Panel (ERP).

#### **Method ERP**

Expert review panels (ERP) are a strategy of asking experts for opinions about a topic or an issue. For this study, an ERP was needed to review the case scenario (developed to describe the enactment of culturally safe nursing) in order to ensure that the scenario was a valid representation of culturally safe nursing practice. Therefore, the purpose of Phase I of this study was to have experts validate culturally safe nursing care as described in a nurse-patient encounter (case scenario). The participants’ collective expertise could validate culturally safe nursing practices in the case scenario, or possibly identify what is missing. The ERP participants were nursing scholars with subject matter expertise in cultural safety. Three cultural safety-nursing scholars were invited to participate in the ERP.

#### **Ethical Considerations**

Ethical approval preceded the commencement of this study. The University of Victoria Human Research Ethics Board (HREB) approved the proposed research and a

certificate of approval was granted in May 2015 (Protocol 15-125; Appendix A). The ERP method was determined to be low on the HREB risk scale, meaning that there was minimal potential harm for participants to take part in this study. The benefit of participating in an ERP and contributing to new knowledge regarding cultural safety was determined to outweigh any associated risks.

Procedures for withdrawal from the study were outlined in the participant consent documents and approved by the HREB. The consent document explicitly described how study information was kept confidential and detailed how participant anonymity was maintained. The consent to participate documents also explained the procedures for ensuring the security of the study data. Details in the consent documentation also outlined the dissemination of results and the data disposal processes.

## **Participants**

### **Sampling**

A purposive sampling method was used in Phase I of this study. Inviting participants who were knowledgeable on the topic to be explored (cultural safety) was critical. Since the origin of cultural safety is found in nursing, nursing scholars were invited to participate in an ERP. An in-depth literature review also explicated six elements and characteristics of culturally safe nursing. For these reasons, the principle investigator began by inviting three culturally safe nursing scholars to participate on an ERP for the purposes of validating culturally safe nursing practices. However, selection bias is known to be a factor when employing purposive sampling and using a small sample size. If conflicting opinions had occurred, increasing access to other cultural safety sources and knowledge might have decreased the effects of selection bias. If there

were divergent opinions in the Phase I ERP results, two additional participants that meet the inclusion criteria would have been located. Once found, the recruitment processes, as outlined below, were followed to invite those participants into the study. Specific inclusion criteria for qualifying participants to take part in this study were as follows:

1. nurses who are teaching on the topic of cultural safety in post-secondary programs,
2. are published in the area of cultural safety,
3. English speaking, and
4. have access to a computer.

Upon initiation of the recruitment processes for Phase I of the ERP, three nursing scholars were contacted. While three cultural safety-nursing scholars were asked to participate, the study was designed so that their contributions were independent from one another and anonymous.

### **Recruitment**

Step 1: ERP potential participants were contacted using publicly available information. Potential participants were contacted from University of Victoria (UVIC) webmail platform. The letter of invitation that was distributed included a description of the purpose of the study and outlined, in general, what participation in the study would entail (see Appendix C).

Step 2: Responses to the letter of invitation were received by email. Individual letters of consent to participate in this study were then prepared for distribution to participants (see Appendix D: Phase I ERP Letter of Consent Template).

Step 3: Consent to participate in this study was then distributed using UVIC email. The consent to participate document described, in detail, the purpose, timeline, risks, and benefits of the study. At that time, potential study participants were also informed of the time commitment and confidentiality requirement in the consent to participate letter. Participants were also made aware there would be no compensation for their efforts.

Step 4: The signed consent forms represented the participant's agreement to take part in this study.

### **ERP Data Collection**

The following outlines the plan for data collection and analysis for Phase I of this study. Participant instructions were distributed to the ERP participants as follows:

1. Read the case scenario, and
2. Read the question then examine the table containing six culturally safe nursing hallmarks (see Table 5: Phase I: Expert Review Panel), then
3. Complete the table and indicate your answer by using a check mark () in the *Yes* or *No* column beside each of the culturally safe nursing hallmarks.

Participants were also invited to provide feedback for a negative response under the 'If your answer is *No* please explain' column. The following question was asked of Phase I ERP participants:

1. "Are any or all of the culturally safe nursing hallmarks represented in the Case Scenario?" (Appendix E: Phase I ERP: Participant Instructions).

Table 5

*Phase 1: Expert Review Panel*

Hallmark of Cultural Safety Nursing	YES	NO	If your answer is “NO” please explain
1. Creating Trust			
2. Relinquishing power over relationships			
3. Approaching people with respect			
4. Seeking permission			
5. Listening with your heart and ears			
6. Attending to the beliefs and practices of those who differ			

An Excel spreadsheet was developed to track the results found in Phase I of this study.

Each participant was assigned a non-identifying numerical code. A sample of the Excel spreadsheet format is shown in Table 6: Phase I Expert Review Panel: Data Analysis.

Participant responses were copied and pasted directly to the appropriate columns.

Repeated ideas found in participant feedback were collected, analyzed, and reported.

Table 6

*Phase 1: Expert Review Panel: Data Analysis*

Participant	Yes	No	No Rationale	Themes
Subject Matter Expert - 001				
1. Creating Trust				
2. Relinquishing power over relationships				
3. Approaching people with respect				
4. Seeking permission				
5. Listening with your heart and ears				
6. Attending to the beliefs and practices of those who differ				

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Subject Matter Expert - 002

1. Creating Trust
2. Relinquishing power over relationships
3. Approaching people with respect
4. Seeking permission
5. Listening with your heart and ears
6. Attending to the beliefs and practices of those who differ

Subject Matter Expert - 003

1. Creating Trust
  2. Relinquishing power over relationships
  3. Approaching people with respect
  4. Seeking permission
  5. Listening with your heart and ears
  6. Attending to the beliefs and practices of those who differ
- 

### **Bias and Study Limitations**

Phase I of this study was designed using a qualitative strategy called an ERP. As cultural safety is a relatively small field of study; the risk of selection bias existed. Researcher bias is also a concern in studies using a qualitative approach. To mitigate threats to the internal validity of this study, the following strategies were employed.

Researcher bias was remediated by choosing study participants whose relationship is at “arm’s length” from the principle investigator. This means that no co-authored publications or collegial association exist, nor did communications between the principle investigator and participants regarding study details occur prior to this study’s commencement.

The selection of study participants, who represented the opinions of the larger groups of culturally safe experts, was taken into consideration. Although selection bias could affect study results when using a small study sample ( $n=3$ ), the opinions of three subject matter experts, all meeting the inclusion criteria, were considered to be

representative of those with authority on the subject of cultural safety. However, it was possible that divergent opinions might occur amongst the ERP experts. In the case that divergent opinions were noted, the research plan was to broaden expertise on the ERP so that other points of view were represented. If divergent opinions were noted during the collection and analysis of study data, the risk of distortion in the interpretation of the results existed. Distortion in results could have jeopardized the internal validity of this study, meaning that the results would not reflect the goal of the study. Mitigating selection and researcher bias was important to ensure data quality and implications for future related research, were preserved.

### **Summary**

Phase I of this study was designed using an ERP. The purpose of Phase I was to validate six culturally safe nursing activities that were enacted by a nurse in a nurse-patient interaction (case scenario). The best way to validate culturally safe nursing practices was to ask for opinions from subject matter experts.

Six hallmarks of culturally safe nursing practice emerged from the literature. A nursing case scenario was developed describing these six hallmarks. The goal of Phase I was to see if experts in the field of cultural safety recognized the six hallmarks in the case scenario. ERP participants had the opportunity to agree or disagree about whether the case scenario represented culturally safe nursing practices.

## CHAPTER 5

### PHASE 1: RESULTS

This chapter presents the results of the expert review panel (ERP) conducted in Phase I of this study. Phase I was guided by the following research questions: “What does culturally safe nursing practice mean, and how do we know when it is being practiced?”

First, it was critical to understand what culturally safe practice means. Generally, the cultural safety literature describes how nurses can learn to practice in this way. Specifically, the cultural safety literature refers to a specific process for nurses to succeed in providing culturally safe care. The second section of the research question was an inquiry about knowing when culturally safe nursing is being practiced. No descriptions or definitions of culturally safe practice were found in the cultural safety literature. Yet, there were six hallmarks that emerged from the literature describing culturally safe nursing practice. A case scenario was created using these six hallmarks to provide a description of what could be interpreted as culturally safe practice. In order to assess the validity of this case scenario, an ERP was asked to review it to determine if it was or was not an exemplar of culturally safe nursing practice. Thus, the goal of Phase I ERP was to have experts validate that a case scenario was providing a recognizable description of culturally safe practice.

#### **Timeline**

Following University of Victoria Human Research Ethics Board approval (Protocol 15-125; Appendix A), Phase I ERP was launched. Letters of invitation to participate in Phase I ERP were distributed in May of 2015. Consent to participate followed once all the participants responded to the initial expression of interest, as

indicated in the letter of invitation. Phase I ERP participant instructions were distributed individually upon receipt of each signed consent document. Table 7 illustrates the timeline between the distribution of the study documents and participant responses. As noted, the timeline for completion of the Phase I ERP was delayed since a (SME 003) participant was temporarily unavailable. Upon email clarification of this participant's commitment, a response, although delayed, was then received. Otherwise, Phase I ERP was completed within a reasonable timeline considering the commitments of the participants.

Table 7

*Phase I ERP Timeline*

Participant	Informed Consent	Instructions	Responses
SME 001	May 2015	May 2015	June 2015
SME 002	May 2015	May 2015	June 2015
SME 003	May 2015	June 2015	July 2015

### **Response Analysis**

Participant instructions were as follows:

1. Read the case scenario, and
2. Respond to the following question: "Are any or all of the culturally safe nursing hallmarks represented in the case scenario?" As noted in Table 8, participants were not asked to identify examples of culturally safe nursing practices within the case scenario, but they were asked to confirm if any or all of the six hallmarks were represented in the case scenario. Participants were also asked to provide additional information if they felt that one or more hallmarks were missing from the case scenario. Response data were collected over a two-month time period, in 2015.

Table 8

*Phase I: Expert Review Panel: Data Collection*

Hallmark of Cultural Safety Nursing	YES	NO	If your answer is “NO” please explain
1. Creating Trust			
2. Relinquishing power over relationships			
3. Approaching people with respect			
4. Seeking permission			
5. Listening with your heart and ears			
6. Attending to the beliefs and practices of those who differ			

### Results

Participants unanimously confirmed that the six culturally safe nursing hallmarks were described in the provided case scenario, as shown in Table 9 Phase I ERP results.

Although no participants indicated a missing hallmark of culturally safe nursing practice, one participant commented on the practice of “Attending to the Beliefs and Practices of Those Who Differ” as follows:

Yes she does but there seems to be an assumption that he does have a traditional healer – perhaps she should ask him if this is the case (one tenet of cultural safety is that we do not assume this – some people do not consult with traditional healers). SME003

In the case scenario, Abby suggested to her patient, John, that he might like to access to a traditional healer. The intent of this example in the case scenario was for it to represent the practice, “Attend to the beliefs and practices of those who differ.” After careful

consideration of the participant comment, the PI decided not to revise the case scenario because a) the scenario contained many overlapping nursing actions, which addressed all of the practices, and b) this participant's response did not indicate disagreement with the practice being present in the scenario, instead the comment highlighted the subtleties of inquiring about cultural traditions.

Table 9

*Phase I ERP Results*

ERP Participant	YES	NO	No Rationale	Themes
Subject Matter Expert - 001				
1. Creating Trust	<input type="checkbox"/>			
2. Relinquishing power over relationships	<input type="checkbox"/>			
3. Approaching people with respect	<input type="checkbox"/>			
4. Seeking permission	<input type="checkbox"/>			
5. Listening with your heart and ears	<input type="checkbox"/>			
6. Attending to the beliefs and practices of those who differ	<input type="checkbox"/>			
Subject Matter Expert - 002				
1. Creating Trust	<input type="checkbox"/>			
2. Relinquishing power over relationships	<input type="checkbox"/>			
3. Approaching people with respect	<input type="checkbox"/>			
4. Seeking permission	<input type="checkbox"/>			
5. Listening with your heart and ears	<input type="checkbox"/>			
6. Attending to the beliefs and practices of those who differ	<input type="checkbox"/>			
Subject Matter Expert - 003				
1. Creating Trust	<input type="checkbox"/>			
2. Relinquishing power over relationships	<input type="checkbox"/>			
3. Approaching people with respect	<input type="checkbox"/>			
4. Seeking permission	<input type="checkbox"/>			
5. Listening with your heart and ears	<input type="checkbox"/>			
6. Attending to the beliefs and practices of those who differ	<input checked="" type="checkbox"/>		Participant comment	

### Summary

Cultural safety is about nurses moving through a process. The process towards culturally safe nursing starts with the recognition that internal and external influences affect practice. Increasing awareness of internal and external influences enhances the opportunity to understand the impact that *power* has in a healthcare provider interaction. Six hallmarks of culturally safe nursing practices were found in the cultural safety literature. Illustrating culturally safe nursing practices in a case scenario presented the opportunity for these hallmarks to be validated by a panel of experts in the field. The collective expertise of participants on the ERP confirmed that the case scenario described and illustrated six culturally safe nursing practices.

## CHAPTER 6

### PHASE II: METHODS

#### **Documenting Culturally Safe Nursing Practices**

Phase II of this research project was concerned with documenting culturally safe nursing practices in an electronic health record using extant standardized nursing terminologies. The purpose of Phase II of this study was to explore expert opinion regarding the documentation of culturally safe nursing practices in a case scenario as an example of nursing care. The goal of Phase II of this study was to inquire into whether culturally safe nursing practices could be documented in the electronic health record (EHR) using current versions of International Classification of Nursing Practice (ICNP®) or Nursing Intervention Classification (NIC). The Phase II research question was, “Can proposed culturally safe nursing practices be coded through use of NIC and/or ICNP®?” To answer this question, two Delphi panels were launched in 2015. One Delphi panel consisted of NIC subject matter experts and the other of experts from ICNP®. The term *intervention* is used to describe the nursing practices, and actions, associated with Phase II of this study. Background information is discussed below before a detailed explanation of the study design and procedures.

#### **International Classification for Nursing Practice**

Arising from the longstanding efforts of the International Council of Nurses (ICN), ICNP® is just one pillar under that organization’s eHealth strategic initiative. Formalized in the year 2000, the ICNP® is sometimes referred to as a classification of nursing phenomena; a unified nursing language system, or a terminology set. Going

forward, the term used to describe ICNP® will be *terminology set* as the focus of this study is the nursing interventions subset of the ICNP®.

The structure of the ICNP® includes nursing diagnosis, interventions and outcomes. Therefore, when ICNP® is enabled in the EHR, electronic documentation of nursing care along the continuum of care from assessments, to interventions, and nursing outcomes is possible. The current (Version 1.0) ICNP® structure is referred to as the 7-axis model. In the 7-axis model nursing diagnoses, interventions or outcomes are allocated to one of the following areas of nursing: 1) focus, 2) judgment, 3) action, 4) means, 5) client, 6) location, and 7) time.

Within the structure of the 7-axis model, each nursing interventions is also assigned a description, as well as individual configurations of parent-child relationships. An example illustrating the *description*, two *parent* and three *children* ICNP® nursing intervention *Ability to Dress* (on the axis *Focus*), is displayed in Table 10.

Table 10

*ICNP® Axis Focus: Nursing Intervention-Ability to Dress*

ICNP® Nursing Intervention	Code	Axis	Description	Parent	Children
Ability to Dress	10000145	Focus	Ability: Putting on or taking off suitable clothes	Ability	Ability to Dress And Groom Self

Ability to

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Perform	Able to Dress
	Impaired Ability to Dress

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A recent ICN initiative has been the development of nursing subsets called ICNP® catalogues. Through formal agreements with national nursing organizations, ICN Research and Development (R&D) teams collaborate with nurses working in specialty areas, to develop ICNP® Catalogues. Currently there are eight ICNP® catalogues covering nursing care specialties such as: 1) Disaster Nursing, 2) Palliative Care, and 3) Community Nursing. While other examples of ICNP® catalogues currently being developed are: 1) Hospitalized Adult Mental Health Client, 2) Pressure Ulcer Prevention, and 3) Special care Nursery. The ICNP® Catalogues facilitate retrievable data for these specialized areas of nursing.

For the following three reasons, ICNP® was selected as the terminology set to explore during this study with respect to culturally safe nursing interventions: 1) ICNP® includes nursing interventions; 2) ICNP® is reported to reflect, “international standards to facilitate the description and comparison of nursing practice locally, regionally, nationally and internationally” (International Council of Nurses, n.p., 2014); and 3) ICNP® was recently recommended by the Canadian Nurses Association (CNA) for use in Canada.

### **Nursing Intervention Classification**

The purpose of developing NIC was to name all nursing interventions generally regarded as included in the discipline of nursing (Bulechek, Butcher, Dochterman, &

Wagner, 2013). The NIC is one component of a larger classification set that includes nursing diagnosis (NANDA I), and nursing outcomes, referred to as Nursing Outcomes Classification (NOC). The focus of this study is NIC.

The hierarchical structure of NIC is organized into seven domains, and 30 classes, under which 550 nursing interventions and their associated definitions and related activities are positioned. An example illustrating one nursing intervention belonging in the NIC Domain: Physiological, Class: Self-Care Facilitation is displayed in Table 11.

Table 11

*NIC Nursing Intervention-Self Care Assistance: Dressing/Grooming*

NIC Nursing Intervention	Code	Class	Definition	Activities
Self-Care Assistance: Dressing/Grooming	1802	Self Care	Assisting Patient with clothes and appearance	<p>Consider Culture of the patient when promoting self-care activities</p> <p>Consider age of patient when promoting self-care activities</p> <p>Inform patient of available clothing for selection</p> <p>Provide patient's clothes in accessible area (e.g. at bedside)</p> <p>Provide personal clothing, as possible</p> <p>Be available for assistance in dressing, as necessary</p> <p>Facilitate patient combing hair, as appropriate</p> <p>Facilitate patient shaving, as appropriate</p> <p>Maintain privacy while the patient is dressing</p> <p>Help with laces, button, and zippers, as needed</p> <p>Use extension equipment for pulling on clothing, if appropriate</p>

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Offer to launder clothing, as necessary  
Place removed clothing in laundry  
Offer to hang up clothing or place in dresser  
Offer to rinse special garments, such as nylons  
Provide fingernail polish, if requested  
Provide makeup, if requested  
Reinforce efforts to dress self  
Facilitate assistance of a barber or beautician, as necessary

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For the following three reasons, NIC was selected as a standardized nursing language to explore during this study with respect to culturally safe nursing interventions:

1) NIC includes nursing interventions; 2) NIC is known to be internationally recognized and is translated in several languages; and 3) NIC applies to various practice settings and is not contingent on any one particular philosophical worldview.

### **Method-Delphi Panels**

The Delphi panel method was selected for this study. Delphi panels are a qualitative method consisting of questions (distributed in rounds) to participants that are interspersed with controlled feedback. The purpose of using this method is to reach consensus from experts in a certain field. The goal of this phase was to see if, experts in both ICNP® and NIC could recognize, then name culturally safe interventions upon reading a case scenario that reflected such care. Three experts in both ICNP® and NIC were invited to participate in separate Delphi panels.

## **Ethics**

Ethical approval preceded the commencement of this study. The University of Victoria Human Research Ethics Board (HREB) approved the proposed research and a certificate of approval (Protocol 15-125; Appendix A) was granted in May 2015.

## **Participants**

### **Sampling**

In Phase II, purposive sampling strategies were employed. Widely discussed in the literature, there are no definitive criterion or standards on sample size for Delphi panel studies; rather, situation-specific metrics are determined (Atkins, Tolson, & Cole, 2005). Both ICNP® and NIC are relatively small fields of study; therefore, a three-person expert panel was chosen to ensure a sound representation of opinions regarding the nursing activities present in each case scenario. Defining the inclusion criteria was based on the overarching premise that the participants must possess substantial knowledge of the development of nursing languages. The specific inclusion criteria for this study were that participants must a) possess substantial knowledge of the development of nursing languages, b) be widely published in this field, d) be English speaking, and e) have access to a computer. The principle investigator had no previous collegial associations with experts in the field of NIC and ICNP®.

### **Recruitment**

The principle investigator contacted the Director of ICNP® at the International Council of Nurses (ICN) with a query about participants for the study. The Director of ICNP®, who was unavailable to assist with recruitment at the time, made a referral to a

colleague at the University of Wisconsin Milwaukee (UWM) who was unknown to the principle investigator. This third party at the UWM contacted ICNP® Research and Development (R&D) teams to solicit potential participants. Once a response was received from the R&D teams, a list of potential participants was sent to the principle investigator. The first three ICNP® experts to express interest in participating in this study were then sent invitation letters by the principle investigator. The letter of invitation that was distributed included the purpose of the study and outlined, in general, what participation would entail (See Appendix F).

Initial inquiry was made to the first author of NIC by one of the researcher's academic committee members. The first author, in turn, contacted a person at the Iowa Center for Classification and Clinical Effectiveness (College of Nursing University of Iowa). This third party inquired into whether "NIC fellows" (who are people with expertise in NIC) might be interested in participating in a study concerning the use of NIC. Interested participants' contact information were then forwarded to the principle investigator by this third party. The first three NIC experts to express interest in participating in this study were then sent invitation letters by the principle investigator. Using the University of Victoria (UVIC) webmail platform, the letter of invitation that was then distributed included the purpose of the study and outlined, in general, what participation would entail (See Appendix G).

Responses to the letter of invitation were received by email from both groups of potential participants. Individual letters of consent to participate in this study were then prepared for distribution to participants (See Appendixes H and I: Phase II Delphi panel [ICNP® and NIC] Letter of Consent template).

Consent letters were then distributed to all potential participants in this study using email. The consent to participate document described, in detail, the purpose, timeline, risks, and benefits of the study. In the consent to participate letter, potential study participants were also informed of the time commitment and confidentiality requirements. Participants were also made aware that there would be no compensation for their efforts.

Individual signed consent forms represented participants' agreement to take part in this study.

### **Data Collection**

The following describes the timeline and plan for data collection and analysis of the Phase II Delphi Panel responses. NIC and ICNP® experts participated in two separate Delphi panels. The six experts (three on each panel) were expected to commit to a total of six hours over a period of one month. It was estimated that each round would require approximately two hours to complete. A two-day cushion was added to the estimated participant response times. Following submission of responses, five days was devoted to response analysis and to distributing controlled feedback to each of the Delphi panels. A time gap of one week was determined to be the maximum time between rounds in order to maintain momentum and participant interest.

Similar instructions were given to both ICNP® and NIC Delphi Panel participants. For each group, every participant was given a table (see Table 12 for an example) to assist in providing feedback. Delphi panel participant instructions included the following:

1. Read the case scenario, and

2. Identify all nursing interventions in the case scenario according to your expertise in ICNP® or NIC.

Table 12

*Delphi Panel: Response Round I: ICNP®*

ICNP®	Response
Round 1:	Nursing Activity #1
	Nursing Activity #2
	Nursing Activity #3
	Nursing Activity #4

Phase II Delphi panel participant instructions were as follows: “According to your (ICNP®)/NIC expertise, please name all nursing interventions noted in the case scenario. Please add rows as needed.” This question was asked to elicit participant responses that would reflect the broad scope of nursing practices—which include physiological, social, and cultural care—according to participant expertise.

### **Data Analysis**

#### **Round 1**

Excel spreadsheets were developed under the headings “Phase II. Delphi Panel: NIC” and “Phase II. Delphi Panel: ICNP®” to collect all participants’ panel round responses. Each participant’s feedback in every round was copied and pasted “as is” according to their subject expertise into an Excel spreadsheet titled “NIC” or “ICNP®” as shown in Table 13. Each subject matter expert was assigned a non-identifying code. The Delphi Panel results remained anonymous throughout the study to ensure participant anonymity.

Analysis of study data occurred after each round of responses was received in order to measure the level of divergent opinions and the strength of the consensus. Tables were developed for each Delphi panel round according to the following format.

Table 13

*Phase II Delphi Panel: ICNP® Participant Responses*

Participant	Responses
Participant 44	#1
	#2
	#3
	#4
Participant 55	#1
	#2
	#3
	#4
Participant 66	#1
	#2
	#3
	#4

**Round 2**

Once submissions were received from Round 1, they were collated into a combined list representing responses and any agreement, as shown in Table 14.

**Round 3**

As responses were collected from Round 2, the level of agreement was collated under headings, as shown below in Table 15. Results were then resubmitted to participants for Round 3 of the Delphi panel.

Table 14

*Participant Response-Level of Agreement*

Question	Response: Nursing Activity	Agreement
Participant 44	#1	
	#2	
	#3	
	#4	
Participant 55	#1	
	#2	
	#3	
	#4	
Participant 66	#1	
	#2	
	#3	
	#4	

Table 15

*Participant Response-Level of Agreement*

Items expressed by 3 participants	Items expressed by 2 participants	Items expressed by 1 participant

Data from Round 3 were then synthesized into controlled feedback and presented to both Delphi panels. Data analysis from Round 3 also informed the Delphi panel study results.

### Summary

The Delphi panel method was used in Phase II of this study. Experts in ICNP® and NIC were invited to participate on separate Delphi panels to explore their recognition of culturally safe nursing interventions in a case scenario. Iterative rounds of questions were distributed and interspersed with controlled feedback, followed by a summarizing of the responses.

## CHAPTER 7

### DELPHI PANEL RESULTS

The purpose of Phase II of this study was to determine if experts in standardized nursing languages (SNL) could document culturally safe nursing care when reviewing a case scenario that included such care. This chapter presents the results of each Delphi panel: one that used the International Classification of Nursing Practice (ICNP®) and one that used the Nursing Interventions Classification (NIC). The results of the ICNP® Delphi panel are presented first, followed by the NIC Delphi panel findings.

#### **ICNP® Delphi Panel**

##### **Round 1**

Following consent, Round 1 ICNP® Delphi Panel instructions were distributed to the three participants (Appendix J). Participants were instructed to name all nursing interventions that they thought were carried out in the provided case scenario. Participants' responses were compared to the current ICNP® version at the time of the study (International Council of Nurses, 2016). The following section represents the findings from the ICNP® Delphi panel.

A total of 44 responses were received in Round 1 (Table 16). Participant responses in Round 1 fell into three categories:

1. ICNP® Nursing Interventions;
2. Responses with similar meaning as ICNP® terms and phrases; and
3. Responses that did not match ICNP® (non-ICNP® nursing activities).

Table 16

*ICNP® Delphi Panel Round 1 Responses*

Participant ID	Response
44	Assessing cultural beliefs Establishing trust Protecting cultural beliefs Involving in decision making process Measuring blood pressure Measuring radial pulse Cultural brokerage Assessing Family support
55	Review charts and shift report Apply knowledge of cultural communication patterns in communication with client Establish therapeutic & trusting relationships through effective cultural communication Creating choices for clients Asking permission Inviting disclosure about family Creating opportunity/space to meet cultural-specific spiritual needs Assess current condition (LOC [Level of Consciousness]), pain, & vital signs
66	Assess pain control Assess family coping process Assess cultural belief Assess exercise pattern Encourage mobility Assess fear of being a burden to others Educate regarding fall risk Educate regarding pain control Assess response to pain medication Verify consent prior to procedure (e.g., dressing change) Inspecting dressing and wound Performing wound care Monitoring IV status Informing patient regarding special room for spiritual ritual Performing dressing change Performing hygiene

Table 16 (continued)

Participant ID	Response
	Monitoring blood pressure
	Monitor for signs and symptoms of infection
	Managing IV (device)
	Managing pain
	Teaching about bowel elimination (post colectomy)
	Changing dressing
	Assessing physiologic status
	Teaching about fluid therapy
	Cultural brokerage
	Identifying psychological status
	Monitoring wound healing

Round 1 participant responses reflected nursing care in the following areas: (a) physiological, (b) cultural, (c) communication, (d) education, (e) family, and (f) relationship development. Participant 66 contributed the most, with 27 responses, while participants 44 and 55 contributed nine and eight responses, respectively. Of note, the responses submitted by participant 55 were received in a narrative format.

Two participants (44, 66) agreed that 2 ICNP® nursing interventions (*Assessing Cultural Beliefs* and *Cultural Brokerage*) were carried out in the case scenario. No responses from participant 55 are represented in Table 17, as they were not exact matches to ICNP® nursing activities.

Table 17 displays 15 potential ICNP® matches to participant responses.

Table 17

*ICNP® Nursing Interventions by Participant*

Participant ID	ICNP® Code	ICNP® Intervention
44, 66	10024233	Assessing cultural beliefs
44, 66	10046099	Cultural brokerage
44	10024396	Establishing trust
44	10026368	Protecting cultural beliefs
44	10026323	Involving in decision making process
44	10031996	Measuring blood pressure
44	10044740	Measuring radial pulse
66	10026254	Assess fear of being a burden to others
66	10030694	Assessing physiologic status
66	10043813	Teaching about fluid therapy
66	10044241	Identifying psychological status
66	10042936	Monitoring wound healing
66	10011660	Managing pain
66	10032052	Monitoring blood pressure
66	10012203	Monitor for signs and symptoms of infection

As seen in Table 18, fifteen responses submitted by participant 66 and single responses from participants 44 and 55 were perceived by the PI to be similar to existing ICNP® nursing terms in meaning, although they did not match the precise language of the ICNP® terms.

Table 19 displays the 10 participant responses not matched to ICNP® (non-ICNP® nursing activities).

Most of the non-ICNP® nursing activities were received from participant 55 and they reflected cultural and relationship-based nursing care. The non-ICNP® nursing activities received from participants 44 and 66 represented physiologically-based nursing care.

Table 18

*Potential ICNP® Matches to Participant Responses*

Participant ID	ICNP® Code	ICNP® Nursing Intervention	Participant Response
44	10036078	Promoting family support	Family support
66	10026119	Assessing pain	Assess pain control
66	10024251	Assess exercise behavior	Assess exercise pattern
66	10036508	Assisting with mobility	Encourage mobility
66	10040253	Teaching about fall prevention	Educate regarding fall risk
66	10019489	Teaching about managing pain	Educate regarding pain control
66	10009872	Implementing pain guideline	Assess response to pain medication
66	10030799	Assessing wound	Inspecting dressing and wound
66	10032863	Surgical wound care	Performing wound care
66	10036583	Maintaining intravenous therapy	Monitoring IV status
66	10036577	Maintaining intravenous access	Managing IV
66	10045131	Wound dressing change	Performing dressing change
66	10032477	Promoting hygiene	Performing hygiene
66	10043558	Teaching about bowel training	Teaching about bowel elimination (post colectomy)
66	10030602	Assessing family process	Assess family coping process
66	10024504	Providing privacy for spiritual behavior	Informing patient regarding special room for spiritual care
55	10024504	Providing privacy for spiritual behavior	Creating opportunity/space to meet cultural-specific spiritual needs

Table 19

*Participant Responses Not Matched to ICNP®*

Participant ID	Participant Response
44	Assessing
55	Review charts and shift report
55	Apply knowledge of cultural communication patterns in communication with client
55	Establish therapeutic and trusting relationships through effect cultural communication
55	Creating choices for client
55	Asking permission
55	Inviting disclosure about family
55	Assess current condition (e.g., Level Of Consciousness [LOC], pain), & vital signs
66	Changing dressing
66	Verifying consent to procedure (dressing change)

Overall, the participant responses (as seen in Tables 17–19) represented the following nursing care areas: (a) physiological (Performing Dressing Change, Measure Blood Pressure), (a) cultural (Assessing Beliefs, Apply knowledge of cultural communication patterns in communication with client), (c) education (Teaching about fluid therapy, (Educate regarding fall risk) (d) family (Assess Being a Burden to others, Assessing family process), and (e) relationship development (Establishing trust, Inviting disclosure about family).

Participants did not limit their responses to the ICNP® nursing interventions actually carried out in the scenario, as per the instructions. Instead, some responses received in Round 1 reflected nursing activities mentioned only in the background information that was provided to participants.

## Round 2

As different approaches were used by each participant to answer the ICNP® Round 1 question, Round 2 controlled feedback was worded to direct participants to review the list from Round 1 (Table 16) responses and to consider *only* the nursing interventions carried out in the case scenario. In addition, the instructions prompted participants to particularly examine Round 1 responses that related to physiological, cultural, and family care (see Appendix K).

ICNP® panel experts responded to Round 2 within 2 weeks of receiving participant instructions. Participant responses were sorted at the level of participant agreement, as shown in Table 20. In Round 2, no new items were added, while six Round 1 responses were dropped. As shown in Table 20, responses reflected physiological and family based nursing care. One non-ICNP® nursing activity, *Assess current condition Level of Consciousness [LOC], pain & vital signs* was included in the participant consensus section. The results of Round 2 showed that participants continued to list responses easily matched to ICNP® nursing interventions. For example, *Informing patient regarding room for spiritual care* and *Creating opportunity/space to meet culturally-specific spiritual needs* were both easily matched with the ICNP® nursing intervention, *Providing privacy to meet spiritual needs* (10024504). Participants also continued to list the nursing activities mentioned in the background information provided in the participant instructions (see Appendix J and Appendix K). For example, *Perform Hygiene, Manage Pain* and *Inspecting dressing and wounds* were mentioned in the background information provided to the participants; however, nursing care reflecting these activities was not carried out in the case scenario.

Table 20

*ICNP® Delphi Panel Round 2 Responses*


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Three Participants
Measuring blood pressure
Measuring radial pulse
Assess current condition (Loss of Consciousness [LOC]), pain & vital signs
Monitoring blood pressure
Assess family coping process
Assess fear of being a burden to others
Family support
Invite disclosure about family
Two Participants
Cultural brokerage
Assessing cultural beliefs
Protecting cultural beliefs
Involving in decision making process
Creating choices for client
Asking permission
Establishing trust
Establish therapeutic & trusting relations through effective cultural communication
Apply knowledge of cultural communication patterns with client
Create opportunities/space to meet cultural specific spiritual needs
Informing patient regarding a special room for spiritual ritual
Assess physiological status
One Participant
Monitoring for signs and symptoms of infection
Teaching about fluid therapy
Monitoring IV device & status
Changing dressing
Perform wound care & monitor wound healing
Performing dressing change
Inspecting dressing and wound
Encourage mobility
Assess exercise pattern
Educate regarding falling risk
Perform hygiene
Teach about bowel elimination (post colectomy)
Manage pain
Assess pain control, and response to pain
Educate regarding pain control
Identifying psychologic status
Verify consent prior to procedures (dressing change)
Review charts and shift reports

---

### Round 3

The first goal of Round 3 was to focus participants' attention on the nursing interventions performed exclusively in the case scenario. The second goal of Round 3 was to determine if participants compared the list of responses in previous rounds to the ICNP® list of terms. The third goal of Round 3 was to determine if participants would suggest whether some of the non-ICNP® nursing activities received in previous rounds might be included in ICNP®. For Round 3, the information in Table 20 was prepared and then distributed to panel participants.

Table 21 lists the ICNP® nursing interventions noted by the participants in Round 3.

Table 21

*ICNP® Delphi Panel Participant Consensus-ICNP® Terms*

ICNP® Code	ICNP® Nursing Intervention
10031996	Measuring blood pressure
10044740	Measuring radial pulse
10032052	Monitoring blood pressure
10030694	Assessing physiological status
10012203	Monitor for signs and symptoms of infection
10024396	Establishing trust
10026323	Involving in decision making process
10026368	Protecting cultural beliefs

Relationship and cultural care based ICNP® nursing interventions were added in Round 3; however, the ICNP® Delphi panel continued to emphasize physiological nursing care. In Round 3, participants reached consensus with respect to the ICNP® nursing interventions *Establishing Trust*, *Involving in Decision Making Process*, and

*Protecting Cultural Beliefs*. As previously discussed and illustrated, the ICNP® nursing interventions structure is called the ICNP® 7-axis model. Each nursing intervention in the ICNP® 7-axis model includes a description and a parent /child referencing framework. Table 22 illustrates the description and parent-child relationships of the Round 3 ICNP® nursing interventions. Notably, no child relationships were assigned to the ICNP® nursing interventions in Table 22.

Table 22

*ICNP® Nursing Interventions Round 3 Results*

ICNP® Nursing Intervention	Description	Axis	Parent	Child
Establishing Trust	Establishing	Interventions	Attending Intervention Establishing Psychological Process Intervention	Not Applicable
Involving in Decision Making	Involving	Interventions	Attending Intervention Involving Psychological Process Intervention	Not applicable
Protecting Cultural Beliefs	Protecting	Interventions	Attending Intervention Protecting Psychological Process Intervention	Not applicable

Two culturally-based nursing terms (as displayed in Table 23) —*Assessing Cultural Beliefs* and *Cultural Brokerage*—were dropped in Round 3 of the ICNP® Delphi panel.

Table 23

*ICNP® Nursing Interventions Dropped in Round 3*

ICNP® Nursing Intervention	Description	Axis	Parent	Child
Assessing Cultural Beliefs	Assessing	Interventions	Assessing Determining Intervention Psychological Process Intervention	Not applicable
Cultural Brokerage	Cultural Brokerage	Interventions	Attending Intervention Care Planning Cultural Brokerage	Not applicable

Table 24 displays the list of non-ICNP® responses that all participants agreed were carried out in the case scenario.

Table 24

*ICNP® Delphi Panel Participant Consensus for Non-ICNP® Responses (non-ICNP® Nursing Activities)*

Non-ICNP® responses
Creating choices for client
Establish therapeutic and trusting relationship through effective cultural communication
Apply knowledge of cultural communication patterns in communication with client
Creating opportunity/space to meet culturally-specific spiritual needs
Informing patients regarding special room for spiritual ritual
Inviting disclosure about family.

The results displayed in Table 24 represent a notable shift from responses recorded in previous rounds. In Round 3, consensus was reached that one non-ICNP® nursing activity, *Informing the patient regarding special room for spiritual care*, could be added to ICNP®. Of note, *Informing patient regarding special room for spiritual ritual* and *Creating opportunity/space to meet culturally-specific spiritual needs* were found to be similar, during the analysis of Round 1 data, to the ICNP® nursing intervention, *Providing privacy for spiritual behavior*. Consensus was also reached that several non-ICNP® nursing activities in the area of cultural care were carried out in the case scenario. For example, *Establish therapeutic and trusting relationship through effective cultural communication* and *Apply knowledge of cultural communication patterns in communication with client* both refer to cultural care. As noted, there are similarities between the non-ICNP® nursing activities and culturally safe nursing activities illustrated in the case scenario.

### **ICNP® Delphi Panel Results Summary**

The results from the ICNP® Delphi panel show that participants reached consensus that eight ICNP® nursing interventions were carried out the case scenario. The ICNP® panel also reached consensus that six non-ICNP® responses were carried out in the case scenario. Participants also reached consensus in Round 3 that *Informing patients regarding special room for spiritual care* was carried out in the case scenario and could be added to ICNP®.

## NIC Delphi Panel

### Round 1

Following consent, Round 1 NIC Delphi Panel instructions were distributed to the three participants (see Appendix I). Participants were instructed to name all of the nursing interventions that they thought were carried out in the provided case scenario. Participant responses were compared to the current NIC version (2013) at the time of the study. The following section represents the findings from the NIC Delphi panel.

A total of 17 responses were received in Round 1 (Table 25). Participant responses in Round 1 fell into three categories:

1. NIC Nursing Interventions;
2. Responses with similar meaning as NIC terms and phrases; and
3. Responses that did not match NIC (referred to as non-NIC nursing activities).

Table 25

*NIC Delphi Panel Round 1 Responses*

Participant ID	Response
77	Identify cultural practices and follow them Listening Emotional support Vital sign monitoring Wound care Pain management Exercise, ambulation Bowel management Diet management
88	Therapeutic touch Vital sign monitoring Complex relationship building
99	Security enhancement Communication enhancement Vital signs monitoring Pain management Cultural enhancement

In general, participant responses reflected nursing care in the following areas: (a) physiological, (b) cultural, (c) communication, and (d) relationship development. Participant 77 contributed seven responses while participants 88 and 99 contributed three and five responses, respectively. Sorted at the level of agreement and consensus, Round 1 results, as displayed in Table 26, represent nine different NIC nursing interventions.

In Round 1, consensus was reached that the NIC nursing intervention, *Vital Signs Monitoring*, was carried out in the case scenario, while two participants agreed that the NIC nursing intervention, *Pain Management*, was carried out in the case scenario. Of note, all three responses submitted by participant 88 were NIC nursing interventions.

Table 26

*NIC Nursing Interventions by Participant*

Participant ID	NIC Code	NIC Nursing Intervention
77, 88, 99	6680	Vital signs monitoring
77, 99	1400	Pain management
77	5270	Emotional support
77	3660	Wound care
77	0430	Bowel management
88	5464	Therapeutic touch
88	5000	Complex relationship building
99	5380	Security enhancement
99	4974	Communication enhancement

Of the remaining five participant responses, three could be perceived as similar to existing NIC nursing terms in meaning, but they did not match the precise language of the NIC terms. Table 27 displays 3 potential NIC matches to participant responses. As displayed in Table 27, participant 77 was the sole contributor in this category.

Table 27

*Round 1 Potential Participant Responses Matched to NIC*

Participant ID	Participant Response	NIC Nursing Intervention
77	Diet management	Nutrition management
	Exercise/ambulation	Exercise Therapy/Ambulation
	Listening	Active listening

Now referred to as non-NIC nursing activities, an additional two responses—from participants 77 and 99, respectively—could not be matched to NIC. *Identify cultural practices and follow them* and *Cultural Enhancement* were not similar to any existing NIC terms.

Overall, the 17 responses received in the NIC Delphi panel Round 1 represented nursing care in the following areas: (a) physiological (Monitoring Blood Pressure, Bowel Management, and Wound Care), (b) cultural, (Identify cultural practices and follow them, Cultural Enhancement), (c) communication (Communication Enhancement, and Listening), and (d) relationship development (Emotional Support, and Complex Relationship Building). Participants did not limit their responses to NIC nursing interventions actually carried out in the scenario, as per participant instructions. Instead, some responses received in Round 1 reflected nursing activities mentioned only in the background information that was provided to participants.

## **Round 2**

As each NIC panel participant used different approaches to answer the Round 1 question, Round 2 controlled feedback was worded to refocus the participants' attention on the NIC list of terms as well as on those nursing interventions carried out exclusively in the case scenario. Participants were sent the response list (see Table 25) received in Round 1 of the NIC Delphi panel. The participant instructions also included a request to consider whether the responses were NIC nursing interventions and, if not, whether they were relevant additions to the NIC. The instructions to participants included a request to only list nursing interventions that were carried out in the case scenario (See Appendix L).

## **NIC Delphi Panel-Results**

Participants in Round 2 reached consensus that the non-NIC nursing activity *Identify cultural practices and follow them* was carried out in the case scenario, but it could be covered under the NIC nursing intervention *Cultural Brokerage*. However, this

term is not included in the NIC. The exact wording of the term is *Culture Brokerage*. Therefore, *Culture Brokerage* was included in the final results of the NIC Delphi panel (see Table 28), and it represents the first of two new terms added in Round 2. Participants also reached consensus that *Listening* is covered under the NIC term *Active Listening*. Therefore, *Active Listening* was included in the final results of the NIC Delphi panel as well. The NIC Delphi Panel participants' consensus is displayed in Table 28.

Table 28

*NIC Delphi Panel Participant Consensus*

Participant ID	NIC Code	NIC Nursing Intervention
77,88,99	4920	Active Listening
77,88,99	5270	Emotional Support
77,88,99	6680	Vital Signs Monitoring
77,88,99	5000	Complex Relationship Building
77,88,99	5464	Therapeutic Touch
77,88,99	7330	Culture Brokerage

Consensus was reached in Round 2 that six NIC nursing interventions were carried out in the case scenario. The NIC panel participants also replaced two responses submitted in Round 1 with NIC nursing intervention terms in Round 2. Eight responses were dropped during Round 2. In the NIC nursing interventions category, (a) Bowel Management, (b) Security Enhancement, (c) Communication Enhancement, (d) Pain Management, and (e) Wound Care were excluded in Round 2. Round 1 responses that were in the “matched to NIC nursing interventions” category—(a) Exercise, Ambulation, (matched to NIC nursing intervention Exercise Therapy/Ambulation) and (b) Nutrition Management (matched to the NIC nursing intervention Diet Management) —were also

excluded in Round 2. Cultural Enhancement was the single non-NIC nursing activity dropped from the list of nursing interventions in Round 2.

In the second and final round of the NIC Delphi Panel, participants reached consensus that six NIC nursing interventions were carried out in the case scenario. Of these six NIC nursing interventions, one represented physiological nursing care: *Vital signs monitoring*. The NIC panel also reached consensus that five NIC nursing interventions representing non-physiological care were carried out in the case scenario. The non-physiological care NIC nursing interventions were (a) *Active Listening*, (b) *Emotional Support*, (c) *Complex Relationship Building*, (d) *Therapeutic Touch*, and (e) *Culture Brokerage*. However, the nursing care provided in case scenario did not include any aspects of *Therapeutic Touch* as described in Table 29.

Table 29

*NIC Delphi Panel Round Results Non-Physiological Nursing Interventions*

Intervention	Definition	Activities
Culture Brokerage	The deliberate use of culturally competent strategies to bridge or mediate between the patient's culture and the biomedical health care system.	<p>Arrange for cultural accommodation</p> <p>Appear relaxed and unhurried in interactions with patient.</p> <p>Modify typical interventions (e.g., patient teaching) in culturally competent ways.</p>
Complex Relationship Building	Establishing a therapeutic relationship with a patient to promote insight and behavioral change.	<p>Create a climate of warmth and acceptance.</p> <p>Identify own attitude toward the patient and situation, repeat as needed.</p> <p>Return at established time to demonstrate trustworthiness and interest in the patient.</p>
Emotional Support	Provision of reassurance, acceptance, and encouragement during time of stress.	<p>Listen to/encourages expressions of feelings and beliefs.</p> <p>Make supportive or empathetic statements,</p>

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Active Listening	Attending closely to and attaching significance to a patient's verbal and nonverbal messages.	<p>Discuss with the patient their emotional experience(s).</p> <p>Focus completely on the interaction by suppressing prejudice, bias, assumptions, preoccupying personal concerns, and other distractions.</p> <p>Listen for the unexpressed message and feeling, as well as content of the conversation.</p> <p>Use silence/listening to encourage the expression of feelings, thoughts and concerns.</p>
Therapeutic Touch	Attuning to the universal energy field by seeking to act as a healing influence using the natural sensitivity of hands and palling them over the body to gently focus, direct and modulate the human energy field.	<p>Identify mutual goals for the session</p> <p>Place hands with palms facing the patient 3 to 5 inches from their body</p> <p>Focus intention on facilitating symmetry and healing in the disturbed areas</p>

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### Summary

Two Delphi panels were launched in 2016. The goal of Phase II of this study was to inquire into whether SNL experts could document culturally safe nursing care through the ICNP® or the NIC when reviewing a case scenario that included such care. After reviewing a case scenario, experts in both ICNP® and NIC were asked to identify all nursing interventions carried out by the nurse in the case scenario. During an iterative series of questions and controlled feedback, experts identified nursing interventions that reflected nursing care in the following areas: (a) physiological, (b) cultural, (c) family, (d) education, (e) communication, and (f) relationships.

Although consensus was reached regarding nursing interventions related to physiological care, ICNP® experts did not reach consensus on what non- physiological

care based ICNP® nursing interventions were present. However, ICNP® experts agreed that six non-ICNP® nursing activities, were carried out in the case scenario. The NIC panel experts identified six non-physiological care based NIC nursing interventions in the final Delphi panel round. The results of these data also indicated that certain terms could be added to or named differently in both ICNP® and NIC. Finally, both panels of experts submitted responses representing non-ICNP® and non-NIC nursing activities that could be easily matched, as well as those that could not be matched to existing ICNP® or NIC terms.

## CHAPTER 8

### DISCUSSION

The study discussed in this thesis was conducted in two phases. The Expert Review Panel (ERP) method was employed in Phase I and the Delphi Panel method was used in Phase II. The study's findings are summarized and discussed in this chapter.

#### **Describing Culturally Safe Nursing**

##### **Phase I Expert Review Panel (ERP)**

The first goal behind conducting this study was to gain a better understanding of the concept of cultural safety and to explore whether it is possible to identify culturally safe nursing practices. The following research question informed Phase I: "What does culturally safe nursing practice mean, and how do we know when it is being practiced?" The papers reviewed on the subject of cultural safety in nursing discussed only relevant guidelines and competencies (Papps, 2002; Ramsden, 2002; Wepa, 2004). While no descriptions of culturally safe nursing practices were found during the literature review, six common ideas about the topic were discovered. The six common ideas were then embedded in a case scenario developed by the principle investigator (PI).

To validate the findings from the literature search, three subjects participated in an ERP. The participants reviewed the case scenario and validated all six of the hallmarks of culturally safe nursing practices:

1. Creating trust,
2. Relinquishing power over relationships,
3. Approaching people with respect,
4. Listening with your heart and ears,

5. Seeking permission, and
6. Attending to the beliefs and practices of those who differ.

### **Phase I Expert Review Panel-Recommendations**

The results of Phase I of this study advance what was previously known about cultural safety, from competencies and guidelines to tangible examples of culturally safe nursing practices. As such the findings in Phase I contributes to new knowledge in the field of cultural safety. As the Canadian Nurses Association (CNA), along with Canadian Indigenous Nurses Association (CINA) and the Canadian Association of Nursing Schools (CASN), all have confirmed that cultural safety is important to include in nursing curricula, the case scenario, including the six culturally safe nursing practices, could be included in cultural safety course curricula in nursing schools. If nursing schools included the case scenario representing culturally safe nursing practices, along with related guidelines and competencies, nurses would be better prepared to care for Indigenous peoples. Finally, the six culturally safe nursing practices should be included as a basic entry to practice graduate requirement, as is the case in New Zealand.

### **Cultural Safety in Nursing Practice**

Performing culturally safe nursing care requires a nurse to engage in a process of self-learning. The process for nurses to achieve culturally safe nursing practice includes being culturally aware and culturally sensitive as well as ensuring that patient(s) feel safe during a health care interaction. This means that nursing education is key, as it enables nurses to progress through the process of increasing their knowledge about themselves in order to become culturally safe practitioners. It is possible that health care organizations can also utilize the case scenario and culturally safe nursing practices (along with related

guidelines and competencies) as content for online learning modules to support the existing workforce of nurses. Once nurses have learned to apply culturally safe nursing practices, trusting, respectful, and power balanced relationships between nurses and their Indigenous patients is possible.

This study is only a first endeavor to identify culturally safe nursing practices. Cultural safety is a relatively new concept for nursing in Canada; therefore, more research is expected as this field of knowledge grows. Thus, while identifying the six culturally safe nursing practices advances what is currently known about these practices, more studies are recommended. Further research may identify more culturally safe nursing practices, adding to the six that have been validated in this study.

Other allied health professionals are also applying cultural safety to their practice areas. Further inquiry is needed to explore whether the findings of the ERP could be applied to other health care professional groups, such as physicians, social workers, pharmacists, and physiotherapists. While developed for nurses, the case scenario and six culturally safe nursing practices could also be adapted for use by other health professionals working in community or hospital settings. Adapting the case scenario and six culturally safe-nursing practices for use by other health professionals might support new learning about culturally safe care for Indigenous peoples.

Research is also recommended to inquire as to whether culturally safe nursing practices also apply to other ethnic groups. While Phase I of the ERP findings might apply to other ethnic groups, cultural safety was developed to inform nurses of how to best to care for the Indigenous people of New Zealand. For this reason, cultural safety is being applied to nursing Canada's Indigenous population. While it is possible that the six

culturally safe nursing practices identified in Phase I are appropriate to use with other ethnic groups other than Indigenous peoples in Canada, further study is recommended.

The most important concept with respect to cultural safety is that patients feel safe enough to determine their own course of healthcare (i.e., self-determined care). Therefore, engaging Indigenous people and other ethnic groups to validate or dispute the six culturally safe nursing practices found in Phase I of this study is recommended. A Participatory Action Research (PAR) study is a suitable method to explore the results of Phase I. Designing a PAR study that creates a “safe space” for Indigenous peoples’ to review and comment on the six culturally safe nursing practices would enrich on the findings of Phase I of this study.

### **Phase I ERP Summary**

Phase I research question was: “What does culturally safe nursing practice mean, and how do we know when it is being practiced?” The results showed that experts had validated all six culturally safe nursing practices. Thus, by having experts validate that the six culturally safe nursing practices were present in the case, more is known about what it means to practice culturally safe nursing, and how it can be practiced.

### **Documenting Culturally Safe Nursing Care**

#### **Phase II Delphi Panels**

The Delphi panel method was used in Phase II of this study. International Classification for Nursing Practice (ICNP®) and Nursing Intervention Classification (NIC) experts were recruited to participate in two separate Delphi panels. Phase II research question was, “Can proposed culturally safe nursing practices be coded through use of ICNP® and/or NIC?” One purpose of using the ICNP® and the NIC is to provide

a list of terms that describe nursing practices for documentation in the Electronic Health Record (EHR). The ICNP® and NIC were chosen to use in this study because they claim to (a) represent a broad spectrum of nursing interventions, (b) represent global relevance, and (c) are translated into several languages. While both are meant to standardize the documentation of nursing care, ICNP® and NIC are structured differently. As reported in Chapter 6, the ICNP® is a polyhierarchical structure meaning that nursing diagnosis, interventions, and outcomes are organized in a nonlinear way. One component of the ICNP® polyhierarchical structure, called the 7-axis model, includes nursing interventions each with a description and parent-child relationship. In contrast, the NIC's hierarchical structure consists of domains, under which 12 classes are listed. Each *class* in NIC lists associated nursing interventions along with their respective definitions and activities. In the final analysis, the different structures of ICNP® and NIC influenced the results of this study as will be discussed.

### **ICNP® Delphi Panel**

Using the Delphi Panel method, the experts on the ICNP® panel proceeded to consensus in three Rounds of review and feedback. Round 3 results show four significant findings. The results of Round 3 show that one ICNP® nursing intervention represented culturally safe care. Also noted, the ICNP® experts identified six non-ICNP® nursing activities that were carried out in the case scenario.

#### **ICNP® Delphi Panel Round Three Finding 1: Easily matched to culturally safe nursing practices.**

In Round 3 the ICNP® experts reached consensus that the ICNP® nursing intervention, *Establishing Trust*, was carried out in the case scenario. As previously

described and illustrated (Chapter 6, Table 10; Chapter 7, Table 22), each ICNP® term located in the 7-axis structure is assigned, what is referred to as a *description*, and parent child relationship. Indeed, the 7-axis structure provides a description and parent referencing term for *Establishing Trust* (as shown in Chapter 7, Table 22). And while the parent terms (Attending, Intervention, Establishing, Psychological, and Process Intervention) do not contribute to an understanding of the meaning of how to enact Establishing Trust, *establishing* and *trust* are known to be common concepts in nursing. Because *establishing* and *trust* are common concepts known in nursing, one could assume that nurses would know how to perform the ICNP® nursing intervention, *Establishing Trust* in a clinical setting. Also, true, *Establishing Trust* is similar in meaning to the culturally safe nursing practice *Creating Trust*, which was validated by experts in Phase I of this study. The common term in both *Establishing Trust* and *Creating Trust* is *Trust*. Known to be a common concept known to nurses; *Trust* is an essential component for cultural safety nursing practice. For these reasons, the ICNP® nursing intervention *Establishing Trust* was determined by the PI to represent culturally safe nursing practice.

**ICNP® Delphi Panel Round Three Finding 2: Not matched to culturally safe nursing practices.**

Participant consensus was also reached that *Protecting Cultural Beliefs* was carried out in the case scenario. As illustrated in Chapter 7, Table 23 *Protecting Cultural Beliefs* has a description (Protecting) and parent terms, those are: 1) Attending, 2) Intervention, 3) Protecting, 4) Psychological, and 5) Process Intervention. However, the parent terms as mentioned do not contribute to an understanding of the meaning of

*Protecting Cultural Beliefs*, or more importantly provide enough information as to how to enact this ICNP® nursing intervention. In general, without a clear definition and/or associated activities, it would be difficult for a nurse to know for certain, they were providing care that represented the ICNP® nursing intervention, *Protecting Cultural Beliefs*. As well, without a clear definition, or associated activities it is difficult to know if *Protecting Culturally Beliefs* represents culturally safe nursing care. The PI recognizes that ICNP® experts agreed that *Protecting Cultural Beliefs* was carried out in the case scenario. However, no references in the cultural safety literature refer to a nurse's ability to protect the *diverse* cultural beliefs of Indigenous peoples. For these reasons, the PI has determined that, *Protecting Cultural Beliefs* is an abstract term without the context specified by a definition and/or associated activities.

**ICNP® Delphi Panel Round Three Finding 3: Non-ICNP® nursing activities.**

In Round 3, participants reached consensus that six non-ICNP® nursing activities were carried out in the case scenario. They are the following:

1. Creating choices for client;
2. Establish therapeutic and trusting relationship through effective cultural communication;
3. Apply knowledge of cultural communication patterns in communication with client;
4. Creating opportunity/space to meet culturally-specific spiritual needs;
5. Inviting disclosure about family; and
6. Informing patient regarding room for spiritual ritual.

Although the participants did not recommend that the six non-ICNP® nursing activities be added to ICNP®, the non-ICNP® nursing activities showed similar meaning to the culturally safe nursing practices validated in Phase I. For example, Apply knowledge of cultural communication patterns in communication with client; Establish therapeutic and trusting relationship through effective cultural communication; and Inviting disclosure about family, all were found to be similar in meaning to, *Attending to the beliefs and practices of those who differ*. Conceptually, the non-ICNP® nursing activities above represent examples of nursing care performed in the case scenario, and are similar in meaning to a culturally safe nursing practice identified in Phase I of this study. Clinically, if a nurse was to perform the non-ICNP® nursing activities identified by panel experts in Round 3 of the ICNP® Delphi panel they would be practicing culturally safe nursing. However, they will not be able to document the non-ICNP® nursing activities using the current version of ICNP®.

**ICNP® Delphi Panel Round Three Finding 4: Easily matched to ICNP®.**

Two responses in the category of “easily matched to ICNP®” are discussed per their relevance to the findings in Phase I, culturally safe nursing practice. While the experts’ recommendation of *Informing patient regarding special room for spiritual care* could be included in ICNP®, they did not identify the similarity between that non-ICNP® nursing activity, and the ICNP® nursing intervention, *Providing Privacy to Meet Spiritual Needs*. Indeed, both *Informing patients regarding special room for spiritual care* and *Creating opportunity/space to meet culturally-specific spiritual needs* had already been noted by the PI to be similar in meaning to *Providing Privacy to Meet Spiritual Needs*. All three phrases are similar to an example of a culturally safe nursing practice, *Attending to the*

*beliefs and practices who differ*, validated in Phase I. *Attending to the beliefs and practices who differ* is represented in the case scenario when the nurse offers to coordinate time for the patient in a dedicated room for local Indigenous groups: “We have the Okanagan room that we could reserve for you if that might work.”

### **Implications of the ICNP® findings.**

In order to answer the Phase II research question, “Can proposed culturally safe nursing practices be coded through use of ICNP® and/or NIC?” it was first important to see if ICNP® experts could assign existing terms reflecting culturally safe nursing care. The results of the ICNP® Delphi panel show that other than *Establishing Trust*, ICNP® experts could not assign ICNP® terms to reflect culturally safe care. However, the ICNP® experts did identify terms that were easily matched to ICNP®, and non-ICNP® nursing activities, that reflected culturally safe care. These data can inform those who use ICNP® through future ICN initiatives. Recent ICN initiatives such as the following, support a discussion with respect to the results of the ICNP® Delphi Panel.

The Canadian Nurses Association (CNA) has recommended the ICNP® as the preferred terminology set for use in Canada (Canadian Nurses Association, 2017). Previous to this recommendation, in 2013, the Registered Nurses Association of Ontario (RNAO), were officially accredited with being the tenth ICNP® Research and Development Centre in the world. The designation is important for RNAO’s contributions to studying nursing’s influence on patient outcomes, especially with respect to their efforts to standardize best practices. The RNAO anticipates that standardized best practices will lead to standardized nursing functions, resulting in standardized electronic documentation using ICNP® in Canada (RNAO, 2017). Newer to the Canadian ICNP®

landscape is the French-Canadian Research and Development (R&D) Centre for ICNP® in 2014 (International Council of Nurses, 2017). As such, the French-Canadian R&D Centre is working to finalize the validation of the French version of ICNP®. As such, it is clear ICNP® is the preferred nursing terminology set to study, and use, in Canada.

Also, the International Council of Nurses (ICN) is positioned to continue the ICNP® expansion into more practice areas. Developers regularly hold reviews and evaluations of the existing ICNP® list of terms. Expanding the ICNP® is achieved collaboratively between the ICN, ICNP® reviewers, and nurses working in a specific setting (ICN, 2017). The ICN also welcomes submissions for new nursing concepts, interventions, and Catalogues of nursing interventions. Cultural safety is a good candidate to add to the ICNP® as a nursing intervention concept. Cultural safety could then be developed into an ICNP® Catalogue of specific terms. Developed into a domain of specific nursing interventions, a *Cultural Safety Nursing Catalogue* would complement the existing ICNP® Catalogues, such as *Disaster Nursing*, *Community Nursing*, and *Palliative Care for the Dying*.

Similarities also exist between the non-ICNP® nursing activities identified by the ICNP® Delphi Panel and examples in the case scenario of culturally safe nursing practices that were validated in Phase I. It is possible the non-ICNP® nursing activities and certain responses that were easily matched, could also contribute to the development of an ICNP® *Cultural Safety Nursing Catalogue*. Both provide the context surrounding the concept of Cultural Safety, which is important to support clinical nurse's appropriate use and documentation of culturally safe nursing interventions. Specifically, a *Cultural Safety Nursing Catalogue* along with associated non-ICNP® nursing activities provide

the context to the concept of Cultural Safety in ICNP®. Generally, a *Cultural Safety Nursing Catalogue* would also further enhance the ICN's goal that ICNP® represent domain specific nursing specialties and, in this case, local, national, and international nursing concerns. Without the addition of the *Cultural Safety* concept and a respective ICNP® Catalogue to ICNP®, nurses in Canada (using the current version of ICNP®) will not be able to fully document culturally safe nursing interventions in the EHR. Not being able to document culturally safe nursing practices using ICNP® would narrow the relevance and applicability of implementing ICNP® in Canada with respect to nursing Indigenous peoples. Without the representation of culturally safe nursing practices in ICNP®, relevant nursing data, and more importantly associated health outcomes data related to that kind of nursing care for Canada's Indigenous peoples would not be available.

### **NIC Delphi Panel**

In Round 2, participant consensus was reached that (a) one physiological based NIC nursing intervention, (b) one representing non-physiological care, and (c) four representing culturally safe nursing care were evident.

#### **NIC Delphi Panel Round 2-Finding.**

Consensus was reached that one physiological care NIC intervention, *Vital Signs Monitoring*, was carried out in the case scenario. In addition, there were four NIC nursing interventions that are relevant to the subject of inquiry—culturally safe nursing practices—and these are discussed here. In Round 2, participants agreed that *Identify cultural practices and follow them* could be covered under the NIC nursing intervention *Culture Brokerage*. The results of the NIC Delphi panel show that (a) *Culture Brokerage*, (b)

*Complex Relationship Building*, (c) *Emotional Support*, and (d) *Active Listening* were among the six NIC nursing interventions carried out in the case scenario that reflected culturally safe nursing practice. The NIC nursing intervention *Therapeutic Touch* was an unexpected response received in in the final Round of the NIC Delphi panel. According to the definition, *Therapeutic Touch* (see Chapter 7, Table 29) was not represented in the case scenario.

NIC is composed of a hierarchical structure that includes 550 nursing interventions. Each nursing intervention is assigned a definition and includes as many as 30 associated activities. An example—*Cultural Brokerage*—follows. Included in the 1<sup>st</sup> Edition of the NIC in 1992, *Culture Brokerage* was then revised in the year 2000, and it now includes 18 nursing activities (NIC, 2013). To compare *Culture Brokerage* with the Phase I culturally safe nursing practice, *Attending to the beliefs and practices of those who differ* associated nursing activities are illustrated in Figure 4.

*Culture Brokerage*: “The deliberate use of culturally competent strategies to bridge or mediate between the patient’s culture and the biomedical health care system” (Bulechek, Butcher, Dochterman, & Wagner, p. 134, 2013).

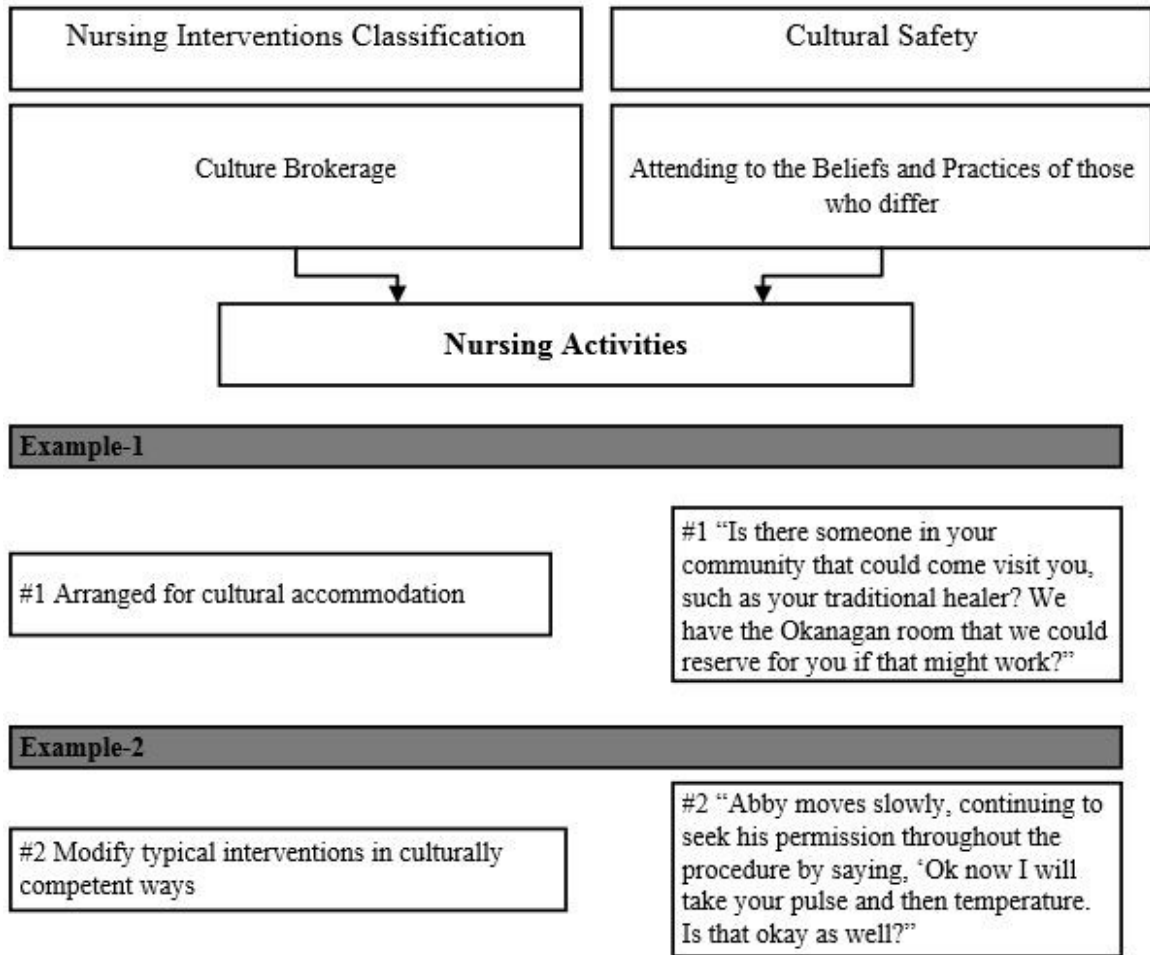


Figure 4. Nursing interventions classification and culturally safe nursing practice.

While NIC developers may have intended *Culture Brokerage* to reflect aspects of cultural care, evidence shows that the NIC structure includes enough information to conclude that it reflects *culturally safe* nursing care as it is described in Phase I of this study.

**Practice Example: NIC and culturally safe nursing practice.**

The EHR is a longitudinal record of a patient's health care information. While streamlining the collection and flow of patient data is known to be one goal of using an EHR, the display screen is the *interface* enabling data entry. The display screen(s) include navigable tabs accessed by mouse clicks. For example, if a SNL such as NIC is

enabled in an EHR; nurses can electronically document nursing care they have performed by clicking on a tab that is labeled, *Nursing Interventions*. NIC nursing interventions are then displayed on the computer screen sorted into the hierarchical structure of NIC (domains and classes); displays can be tailored to suit core practices of certain specialty areas; or sorted into personal libraries representing core practices of an individual nurse. Lists of associated activities are also sorted accordingly, further describing the essence of each nursing intervention, however NIC developers suggest that a paper copy of NIC is available for quick reference (Bulechek, Butcher, Dochterman, & Wagner, 2013).

Using clinical judgment, nurses select a NIC nursing intervention based on the desired patient outcome. Based on the results of the NIC Delphi Panel, if nurses desire a culturally safe outcome for their Indigenous (or possibly members of other ethnic groups) patients and provide that care, e-documentation of that care is possible if NIC is enabled in the EHR. If nurses are able to e-document culturally safe nursing care in the EHR, these data are available for collection, analysis, and tracking. Tracking culturally safe-nursing interventions that are performed with Indigenous patients can, in turn, inform associated patient outcomes.

#### **Delphi panel results-discussion.**

The ICNP® Delphi Panel results show that ICNP® as it currently exists consists of abstract terms such as *Protecting Cultural Beliefs*, and others that are not well defined. Abstract and not well defined: *Protecting Cultural Beliefs* therefore has limited clinical applicability. As such, recommendations for adding a *Cultural Safety Nursing Catalogue* outlined how culturally safe nursing interventions could be added and therefore coded, in ICNP®. The results of the NIC Delphi Panel show that culturally safe care is represented

in NIC. Because culturally safe nursing care is represented in NIC, a practice example was given outlining how practicing in this way could lead to capturing relevant data.

### **Standardized Nursing Languages and Terminology Sets and Nursing Practice**

Papers have been written about the benefits of the standardization of nursing interventions language; from communication between nurses; between nurses and other health providers; ensuring access to digital nursing data, to the effect on health policy development, and most importantly patient care (Doyle, 2006; Lundberg, Warren, Brokel, Bulechek, Butcher, McCloskey Dochterman, Johnson, Mass, Martin, Moorhead, Spisla, Swanson, & Giarrizzo-Wilson, 2008; Jones, Lunney, Keenan, Moorhead, 2011). While the value of standardizing nursing interventions is well documented, the results of this study highlight that not all systems are the same with respect to documenting culturally safe nursing practices.

This study highlighted the difference between two such nursing language systems, ICNP® and NIC. ICNP® is structured in such a way that presumes nurses know how to perform each ICNP® nursing intervention, and that assumption is true if the nursing intervention is a core task relevant to their area of daily practice. However, nurses won't necessarily know how to perform, *Protecting Cultural Beliefs* having just the term available to guide them while documenting their care. The ICNP® nursing intervention, *Cultural Brokerage* as now discussed, illustrates this point. While it remains unknown why the experts dropped this response in Round 2 of the ICNP® Delphi Panel, it is interesting to explore this result further. It is possible that more information is needed to confirm this ICNP® nursing intervention was indeed carried out in the case scenario, as well. If ICNP® experts were not able to reach consensus that *Cultural Brokerage* was

carried out in the case scenario, it is unlikely that a nurse would know how to carry out *Cultural Brokerage*, without more information being available. As in the case of *Protecting Cultural Beliefs*, *Cultural Brokerage*, without a definition or associated activities is also an abstract concept. Meanwhile, if a nurse was to select the NIC nursing intervention *Culture Brokerage* in the EHR, an activities list as illustrated above appears to inform and guide that particular practice. And while this study was not meant to compare systems, the results show that how ICNP® and NIC are structured, affected the study results with respect to culturally safe nursing practices.

Papers have been written about the attributes of standardization of nursing language in general. Comparative and cross mapping studies that report the benefits of one system over another, are also noted in the literature (Moorhead, McCloske & Bulecbe, 1993; Hyun & Park, 2002). As well, specialized areas of nursing that have developed their own standardized nursing language, such as the Perioperative Nursing Data Set. The Perioperative Nursing Data Set (PNDS) is as a standardized nursing language specific to perioperative nursing practice (Peterson & Kleiner, 2011).

Still, other health related languages are used in hospital settings, such as the Laboratory Information Systems, that authorize health providers to view lab test results regardless of the location of service provision (Canada Health Infoway, 2017).

From Hippocrates through to modern times the construction and systematic categorization of language has been a topic for study. Indeed, the history and evolution of terminologies is interesting to note, with respect to the results of this study. Considered to be the modern father of *Terminology and Classification*, William Farr (1807-1883) categorized deaths by disease, and thus the catalogue known as *Vital Statistics* came to be

known (Elkins, 2012). In fact, several health and nursing terminology sets and standardized languages arise from the formative thinking of Hippocrates, and seminal work of William Farr: ICNP® and NIC are just two examples.

The basic unit of any health or nursing standardized languages or terminology set is: a concept. The required components for a concept to be included in a standardized nursing language or terminology set, are the following: 1) Concept orientation, 2) Non-redundancy, 3) Non-ambiguity, and 4) Internal consistency. While concept orientation refers to the basic unit of a terminology, a concept cannot be repetitive, ambiguous in meaning, and must be uniform across domains within the terminology (Elkin, 2012). Other foundational components of a terminology set are *systematic* or *formal definitions* that are assigned to each concept (Elkins, 2012). *Systematic definitions* are constructed using plain language that is not computable, as described above, and are part of the NIC structure. While *formal definitions*, like those in ICNP®, are computable and constructed using a description logic model. As such, if the Cultural Safety concept in of itself was added to ICNP®, along with a description (*formal definition*) and parent child relationship, it is unlikely a nurse will know how to implement that nursing intervention.

Within the current structure of ICNP®, the only solution for documentation of culturally safe care in the EHR is a domain specific *Cultural Safety Nursing Catalogue*. Developing a *Cultural Safety Nursing Catalogue* (along with relevant nursing education and professional development), using the six culturally safe-nursing practices validated in this study. Documenting culturally safe care using ICNP® will electronically communicate this kind of care has been given, and will result in the desired patient outcome: Cultural Safety.

### **Limitations of the Study Design**

While the results of study succeeded in answering both research questions, study limitations relevant to Phase I ERP and/or Phase II Delphi panels are recognized, and are explained below.

#### **Purposive Sampling**

The purpose of the Phase II Delphi panels was to provide participants with an opportunity to review a case scenario based on their knowledge of ICNP® or NIC. The participants were recruited using the purposive sampling method. Whenever purposive sampling strategies are employed in a study, there is potential for selection bias to occur. For this reason, suggestions follow with respect to inclusion criteria, and future studies.

#### **Inclusion Criteria**

The principle investigator noted that a study participant recruited by purposive sampling may or may not have, met one study inclusion criteria. At this time, it remains unknown whether participant 44, though recruited through the ICNP® Research and Development teams, is published in the field of ICNP®. However, participant 44's responses reflected expert knowledge of ICNP® terms. As such, the PI determined that the results of the ICNP® Delphi panel were not compromised.

#### **Sample Size**

The sample size for the ERP and each ICNP® and NIC Delphi panel was small ( $n=3$ ) and, therefore, the results may not be transferrable to other contexts. The conclusions drawn in this study are also open to further interpretation, as others replicating this study may not produce the same results. The PI realizes that this small

study provides only a starting point for gaining further knowledge about describing and documenting culturally safe nursing practices.

### **Timelines**

The decision rules for participant responses set at the beginning of this study affected the study's schedule in the Delphi panels. Delayed timelines for providing controlled feedback to panel participants impacted both ICNP® and NIC Delphi panels. In all rounds, there was a delay in providing controlled feedback to panel participants. The delay, in turn, affected the study's momentum. Both ICNP® and NIC Delphi panels exceeded the four week timeline outlined in the study design.

### **Participant Instructions**

In both Delphi panels, a pattern of participant responses was noted. Participants' responses included nursing interventions and activities only mentioned in the background information. The background information was developed to provide general patient information, in this case, prefacing the content of the case scenario. Despite the fact that the participant instructions clearly requested, "please name all nursing interventions in the case scenario according to your ICNP® (or NIC) expertise," and because both panels included nursing activities and interventions in their responses to that effect, it is clear that the background information diverted participants' attention from the objective of Round 1. Since the Round 1 results reflected nursing interventions and activities included in the background information, Round 2's controlled feedback instructed participants to review the case scenario again. While participant responses reflected the nursing care in the case scenario in the final rounds of both Delphi panels, if similar studies are commenced, excluding the background patient information is recommended.

## **Future Studies**

Opportunities exist to advance the findings of this study. Fine-tuning aspects of the study design is recommended. The study design included background information in the participant instructions, and a case scenario. Excluding the background information to prevent participant distraction is recommended, as previously discussed. Conducting this study with larger participant groups may elicit different opinions about culturally safe nursing practices (Phase I: ERP) or more insight into the existence of nursing interventions representing cultural safety in both ICNP® and NIC (Phase II: Delphi panels). Finally, expanding the Delphi panel's inclusion criteria in similar studies to include nurses who regularly use ICNP® and NIC in clinical practice is encouraged. It is possible that clinical nurses with a working knowledge of ICNP® and NIC might provide further insight according to their level of expertise.

In addition to changes to the study design, further inquiry is recommended to discover if culturally safe nursing practices exist and/or could be documented using other nursing languages. For example, nursing languages such as the Clinical Care Classification System (CCC) and the Omaha system are appropriate options. While both the CCC and the Omaha Systems are not as widely used as ICNP® and NIC, they do include nursing interventions. Since they each include nursing interventions, their systems may also reflect culturally safe nursing practice.

## **Conclusion**

Cultural safety, ICNP®, and NIC originate from the ideas of nurse pioneers. Originating from the lived experience and scholarship of Irihapeti Ramsden (1943-2003), cultural safety was known to unsettle the prevailing colonial notions of nursing care in

New Zealand. Now, interest is being shown in Canada in adopting Cultural Safety into nursing education and practice. Identifying six culturally safe-nursing practices expands the work of Irihapeti Ramsden and other cultural safety-nursing pioneers, such as Diane Wepa and Elaine Papps. Formal nursing languages play an important role in describing and documenting nursing actions. Validating culturally safe nursing practices exist, and further ensuring they are represented in SNL and terminology sets and thus coded for use in an EHR, will contribute to the capture of data relevant for nursing Canada's Indigenous peoples.

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APPENDIX AHUMAN RESEARCH ETHICS CERTIFICATE

PRINCIPAL INVESTIGATOR: Adrienne Lewis	ETHICS PROTOCOL NUMBER 15-125 Minimal Risk - Delegated
UVic STATUS: Master's Student	ORIGINAL APPROVAL DATE: 11-May-15
UVic DEPARTMENT: NURS	APPROVED ON: 11-May-15
SUPERVISOR: Dr. Noreen Frisch; Dr. Karen Courtney	APPROVAL EXPIRY DATE: 10-May-16
PROJECT TITLE: Capturing Culturally Safe nursing practices	
RESEARCH TEAM MEMBER None	
DECLARED PROJECT FUNDING: None	
CONDITIONS OF APPROVAL	
<p>This Certificate of Approval is valid for the above term provided there is no change in the protocol.</p> <p><b>Modifications</b> To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.</p> <p><b>Renewals</b> Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.</p> <p><b>Project Closures</b> When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.</p>	
<b>Certification</b>	
<p>This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Research Regulations Involving Human Participants.</p>	

APPENDIX B

LITERATURE REVIEW-CULTURAL SAFETY

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APPENDIX CLETTER OF INVITATION-ERP**Letter of Invitation-Expert Review Panel (ERP)**2015**Title of Study: Capturing Culturally Safe Nursing Practice**

**Principal Investigator:** Adrienne Lewis, Student, Department of Human and Social Development, University Victoria.

**Faculty Supervisor:** Dr. Noreen Frisch, School of Nursing, Faculty of Human and Social Development, University of Victoria. Dr. Karen Courtney, School of Health Information Science, Faculty of Human and Social Development, University of Victoria.

I, Adrienne Lewis as a graduate student enrolled in both Nursing and Health Information Science, invite you to participate in a research project entitled Describing Culturally Safe Nursing Practice. Specifically you are requested to participate in this study as you are published and/or teaching in the area of Cultural Safety.

Considered to be a subject matter expert on the subject you will be requested to participate on an Expert Review Panel.

The purpose of this research project is to identify nursing practices that would represent the enactment of culturally safe care.

Should you choose to participate, you will be asked to review a nursing case scenario and provide your feedback. The timeline is expected to be one hour and will use email as the communications platform. Should you choose to respond as a general expression of interest to participate in this study, I will forward a formal consent form providing you with further details of this study, for your signature.

If you have any questions, please feel free to contact me, or my academic supervisors (see below for contact information).

Thank you,

Adrienne Lewis  
Graduate Student

Dr. Noreen Frisch (nfrish@uvic.ca)

Dr. Karen Courtney (court009@uvic.ca)

This study has been reviewed and received ethics clearance through University of Victoria Research Ethics Board-Ethics File Number 15-125.

## APPENDIX D

### CONSENT TO PARTICIPATE PHASE I

#### **University of Victoria Participant Consent Form:**

**Project Name:** Describing culturally safe nursing practice.

You are invited to participate in a study being conducted by Adrienne Lewis.

Adrienne Lewis is a graduate student at the University of Victoria in the department of Nursing and Health Information Science.

As a Graduate student, Adrienne Lewis is required to conduct research as part of the requirements for a degree in Nursing Science and Health Information Science. Her research is being conducted under the supervision of Noreen Frisch PhD., and Karen Courtney PhD. You may contact either supervisor by email at nfrisch@uvic.ca., or court009uvic.ca respectively.

#### **Goal and Objective:**

The goal of this research is to describe culturally safe nursing interventions.

Objective: Consult with experts in the field of cultural safety to determine:

1. If culturally safe nursing activities are represented in a case scenario.

#### **Importance of this Research:**

The importance of this research is that cultural safety principles guide nursing practice in unique ways. These unique practices can influence engagement with Indigenous patients. If culturally safe nursing interventions be succinctly defined, then as such the scope of nursing practices is broadened.

#### **Participant selection:**

You are being asked to participate in this study because as a subject matter expert, you possess a broad knowledge of cultural safety.

#### **Time commitment:**

If you consent to take part in this study your participation will include, an estimated one hour of participation in an expert review panel. Partaking in this research will be from a location of your choosing.

#### **Inconvenience:**

Participating in this research will cause you the inconvenience of time spent participating in an expert review panel. Those who consent to participate will devote time to review a case scenario to confirm or deny the presence of culturally safe nursing interventions and explain a negative response.

## **Risks**

There are no known or anticipated risks to you by participating in this research.

## **Benefits**

Potential benefits of participating in this research include:

1. A contribution to knowledge and understanding of culturally safe nursing practices.
2. A further benefit might be that substantiating nursing care that reflects cultural values might serve the expansion of existing standardized nursing languages.
3. Finally, culturally safe nursing practices represent the holism of nursing practice for Canada's First peoples and therefore have the potential to improve health outcomes.

## **Voluntary Participation**

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw through submitting an email to [alewis@uvic.ca](mailto:alewis@uvic.ca) stating your intent to withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be destroyed within 10 days of the receipt of your request to withdraw and therefore not used as part of this research project in any manner or form.

## **On-going Consent**

To make sure that you continue to consent to participate in this research, the researcher will elicit your ongoing consent to participate at each researcher participant communication.

## **Participant's de-identified information:**

To ensure that participant's data is de-identified, I will assign a unique, non-identifiable number code to each participant. The match list linking your identity to your code number will be secured and stored separately from any of your de-identified responses/data. This system will remain in place throughout the research life cycle.

## **Confidentiality**

Safeguarding information and data collected during this study is of utmost priority. Specific measures to ensure the confidentiality and the security of all your personal information and data during the full extent of this research project will be prioritized as per the ethical obligations of University of Victoria HREB. However complete assurance of confidentiality cannot be guaranteed due to small number of subject matter experts in this specialized body of knowledge.

Upon the completion of the study and at the request from a participant this researcher shall return all contributing information received during the Delphi panel process upon receipt of written request within ten (10) days of such request.

All remaining contributing information, in this researcher's possession after the completion of her work will be securely archived for seven (7) years. Following that

period of time the researcher shall provide a written certificate to participants regarding destruction processes.

Data collected during Phase II will be protected, stored and secured by the following means:

- Locked file cabinet.
- Password protected computer and digital files.

Compiled data such as the following will be protected and securely stored in a locked file cabinet. Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways:

1. Published article
2. Presentations at scholarly meetings
3. University of Victoria Thesis portal-UVicSpace.

### **Disposal of Data**

It is important to state data derived from this research, is not intended to be used in future research.

All remaining contributing information in this researcher's possession after the completion of her work will be destroyed to protect the confidentiality of said information. Disposal of information will occur seven years after final analysis of all study data. This researcher shall provide a written certificate participants regarding destruction within ten (10) days thereafter.

Raw data from this study will be disposed of following the publication of research reports and thesis submission. Electronic data will be erased and purged from all digital files; paper copies will be shredded. No secondary research will be conducted using any data from this study.

### **Contacts**

Individuals that may be contacted at the addresses above regarding this study include:

- Adrienne Lewis
- Noreen Frisch
- Karen Courtney

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or [ethics@uvic.ca](mailto:ethics@uvic.ca)).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

---

*Name of Participant*

*Signature*

*Date*

***A copy of this consent will be left with you, and one copy is to be signed, scanned and sent to the researcher at [alewis@uvic.ca](mailto:alewis@uvic.ca)***

## APPENDIX E

### PARTICIPANTS INSTRUCTIONS PHASE I: EXPERT REVIEW PANEL

#### **Background:**

This researcher has developed the following case scenario. The importance of this research is that cultural safety principles guide nursing practice in unique ways. These unique practices can influence successful engagement with Indigenous patients. If culturally safe nursing interventions can be succinctly defined, the scope of nursing practices is broadened.

#### **Participant Instructions: Step 1:**

Read through Case Scenario

#### **Step II:**

Review the table below containing six culturally safe nursing hallmarks answering the following question “Are any or all of the culturally safe nursing hallmarks represented in the Case Scenario?”

#### **Step III:**

Complete table “YES” or “NO” (please include a rationale if the answer is “NO”).

#### **Step IV:**

Return this document using “Describing Culturally Safe Nursing Practice Phase I” in the subject line to the confidential email address: [alewis@uvic.ca](mailto:alewis@uvic.ca)

#### **Step I: Case Scenario-The patient:**

John Charlie is a First Nations elder. Belonging to the Sxwepenc Nation, located within the Interior of B.C., he a member of a large family. Of his seven children, only four are surviving. John has been living alone in a small home since his wife passed away 10 years previous. His home has wood and electric heat and he stays active chopping his own wood in the winter and doing his own cooking. Apart from home support once a week from the band home and community care program he remains independent enjoying regular family visits.

#### **History of Presenting Problem:**

Although he has experienced abdominal pain off and on for years, John had refused to see his doctor. However yesterday his daughter came to bring John lunch and found him uncharacteristically still in bed at 11 am she also noted upon arrival that the house was cold. Although he remained stoic, she pressed him as she noticed he was pale, sweating and unkempt. After a short while denying anything was wrong, John admitted he hadn't eaten due to increasing stomach pain for two days. His daughter then called 911 and

phoned family to assist until the ambulance arrived.

### **Patient Presentation and Assessment:**

Upon admission, and following assessment by the Emergency Physician it was determined by a CT scan and complete blood work up that John had evidence of long standing diverticulitis in the large intestine. While the CBC showed elevated WBC count, the CT scan ruled out the presence of abscess, fistula, obstruction or rupture. Determined to be low a surgical risk due to mild untreated hypertension (148/90) as John's only comorbid condition, he was admitted, Intravenous Morphine (2 mg) and pre surgical IV antibiotics (Keflex 500 mg) were initiated by the emergency department nurses. Surgery was then scheduled the next day to resect a six-inch portion of the affected transverse colon. Feeling improved after receiving IV analgesics, John admitted to his family his long-standing abdominal pain.

### **Family supports:**

It was decided by the family that his oldest daughter Nila would remain with John during the days of recover however many family members were in attendance in the waiting room before his surgery. It was anticipated by the surgeon that John would be in the hospital for 7 days.

### **Hospital Kardex:**

Room: 324 Name: John Leslie Charlie Preferred Name: John DOB: November 24, 1930 Age: 74	Allergies : KNA Drug : Food : Environment:	Plan: Mobilize as tolerated, plan for discharge 7 days post op	IV: Heparin lock
Primary Diagnosis: Diverticulitis	Height: 5'9"	Diet: Day 4, Soft	
Secondary Diagnosis: Mild Hypertension	Weight : 184lbs	ADL's: Minimal assist Adaptive Equipment: N/A	Activity: Up in chair Physio: Daily

Estimated Length of Stay: 7 days		Bladder: continent	
Surgery: Simple Bowel Resection Date: December 4, 2014		Bowels: post operative Laxative x 8 days.	Drain/Dressing/Wound: Staples, Mepore
Religious/Spiritual Affiliation: First Nations – Sxcwepenc Nation	NOK: Daughter Nila Son: George		

### Case Scenario:

Following morning report and a review of her charts Abby, walks into room #324 to find her assigned patient John Charlie sitting up in bed. Noting that John appears comfortable Abby introduces herself making eye contact “I am your nurse for today” she states and then asks permission to sit down in the chair beside the bed. While pulling the chair up beside the bed, Abby notices that although John initially made eye contact as he acknowledges her introduction, he soon looks away. Abby follows his cue, and does not attempt to hold his gaze.

Initiating further conversation by acknowledging what brought John into the hospital, Abby inquires, “I know you have had a hard couple of days and I am interested in what has happened to you”. Abby reaches out to touch John’s hand briefly at the same time she touches her own chest and nods her head as he describes what has happened. “This has been tough for you” Abby suggests and that succeeds in eliciting more information from John. Continuing to follow his story, Abby nods her head indicating that she is interested and attentive. She then inquires “And how are you today?” Abby notes John, sighs and laughs softly, “Well I think I am on the mend now” and she nods her head and returns his tentative smile.

Standing up and approaching John’s bed only when has finished describing his current condition and the conversation has slowed Abby asks, “Can I take your blood pressure, would that be okay?” As John nods his head, Abby intentionally starts with the least invasive vital sign measurement first; she takes his blood pressure (130/28) then pulse (72 and regular) and notes upon taking his temperature he is afebrile. Throughout performing these interventions Abby moves slowly continuing to seek his permission throughout the procedure by saying, “Ok now I will take your pulse and then temperature is that okay as well?”

Looking for ways to continue to create trust as she is performing vital signs Abby inquires, “Has your family been to visit?” Showing interest in his responses she notes

John becomes more engaged in conversation when he speaks of his family. Abby asks further questions like, “Where are you from?” Continuing to show interest while she is learning more about John’s family, Abby also offers “My family also lives close by”. As Abby now senses even more ease in the conversation, she inquires “Is there someone in your community that could come visit you such as your traditional healer? We have the Okanagan room that we could reserve for you if that might work?” When John responds with “I will think about that” Abby moves the conversation to ask when would be a good time to change John’s abdominal surgical dressing. “John can I come back after breakfast and change your dressing? I’d like to hear more about your family as well” When John responds “yes” Abby thanks him for the visit and confirms she will be back after breakfast.

### Step II:

#### Culturally safe nursing hallmarks:

1. Creating Trust
2. Relinquishing power over relationships
3. Approaching people with Respect
4. Seeking permission
5. Listening with your heart and ears
6. Attending to the beliefs and practices of those who differ

### Step III: Complete

Hallmark	YES	NO	If your answer is “NO” please explain
1. Creating Trust			
2. Relinquishing power over relationships			
3. Approaching people with respect			
4. Seeking permission			
5. Listening with your heart and ears			
6. Attending to the beliefs and practices of those who differ			

### Step IV:

Return this document using “Capturing Culturally Safe Nursing Practice Phase I” in the subject line to: [alewis@uvic.ca](mailto:alewis@uvic.ca)

Thank you for your participation.

APPENDIX FLETTER OF INVITATION: INTERNATIONAL CLASSIFICATION OF NURSING  
PRACTICE (ICNP®)**Title of Study: Documenting Nursing Practice**

Principal Investigator: Adrienne Lewis, Student, Department of Human and Social Development, University of Victoria.

Faculty Supervisor: Dr. Noreen Frisch, School of Nursing, Faculty of Human and Social Development, University of Victoria. Dr. Karen Courtney, School of Health Information Science, Faculty of Human and Social Development University of Victoria.

I, Adrienne Lewis as a graduate student enrolled in both Nursing and Health Information Science, invite you to participate in a research project entitled Documenting Nursing Practice. You are being asked to participate in my thesis research project because you are identified as a subject matter expert in the International Classification of Nursing Practice (ICNP®).

My research involves learning how unique nursing practices can be included in EHRs. If you are interested in participating in my study, reply to this e-mail to participate on a Delphi panel that will be formed for one month and will use email as the communications platform. Should you choose to respond as a general expression of interest to participate, I will then forward a formal consent form providing you with further details of this study, for your signature.

The importance of this research is that unique nursing practices are relevant in certain contexts. Documenting those activities in ICNP® would potentiate inclusion in the electronic health record representing the broad scope of nursing practices.

If you have any questions, please feel free to contact me, or my academic supervisors (see below for contact information).

Thank you,

Adrienne Lewis

[alewis@uvic.ca](mailto:alewis@uvic.ca)

Dr. Noreen Frisch ([nfrish@uvic.ca](mailto:nfrish@uvic.ca))

Dr. Karen Courtney ([court009@uvic.ca](mailto:court009@uvic.ca))

This study has been reviewed and received ethics clearance through University of Victoria Research Ethics Board-Ethics File Number 15-125.

APPENDIX GLETTER OF INVITATION: NURSING INTERVENTION CLASSIFICATION (NIC)**Title of Study: Documenting Nursing Practice**

Principal Investigator: Adrienne Lewis, Student, Department of Human and Social Development, University of Victoria.

Faculty Supervisor: Dr. Noreen Frisch, School of Nursing, Faculty of Human and Social Development, University of Victoria; Dr. Karen Courtney, School of Health Information Science, Faculty of Human and Social Development University of Victoria.

I, Adrienne Lewis as a graduate student enrolled in both Nursing and Health Information Science, invite you to participate in a research project entitled Documenting Nursing Practice. You are being asked to participate in my thesis research project because you are identified as an expert in the Nursing Interventions Classification (NIC).

My research involves learning how unique nursing practices can be included in Electronic Health Record (EHR). If you are interested in participating in my study, reply to this e-mail to participate on a Delphi panel that will be formed for one month and will use email as the communications platform. Should you choose to respond as a general expression of interest to participate in this study, I will then forward a formal consent form providing you with further details of this study, for your signature.

The importance of this research is that unique nursing practices are relevant in certain contexts. Documenting those activities in NIC would potentiate inclusion in the EHR representing the broad scope of nursing practices.

If you have any questions, please feel free to contact me, or my academic supervisors (see below for contact information)

Thank you,

Adrienne Lewis

[alewis@uvic.ca](mailto:alewis@uvic.ca)

Dr. Noreen Frisch ([nfrish@uvic.ca](mailto:nfrish@uvic.ca))

Dr. Karen Courtney ([court009@uvic.ca](mailto:court009@uvic.ca))

This study has been reviewed and received ethics clearance through University of Victoria Research Ethics Board-Ethics File Number 15-125

## APPENDIX H

### CONSENT TO PARTICIPATE PHASE II- ICNP®

#### **University of Victoria Participant Consent Form**

**Project Name:** Documenting nursing practice.

You are invited to participate in a study being conducted by Adrienne Lewis.

Adrienne Lewis is a graduate student at the University of Victoria in the department of Nursing and Health Information Science.

As a Graduate student, Adrienne Lewis is required to conduct research as part of the requirements for a degree in Nursing Science and Health Information Science. Her research is being conducted under the supervision of Noreen Frisch PhD., and Karen Courtney PhD. You may contact either supervisor by email at: nfrisch@uvic.ca., or court009uvic.ca respectively.

**Goals and Objectives:** The goal of this research is to document nursing interventions.

**Objective:** Consult with experts in the field of nursing languages sets to determine:

1. If nursing activities as presented in a case scenario can be coded in International Classification of Nursing Practice ICNP®.

#### **Importance of this Research**

The importance of this research is that unique nursing practices are relevant in certain contexts. Documenting those activities in ICNP® would potentiate inclusion in the electronic health record representing the broad scope of nursing practices.

#### **Participant selection:**

You are being asked to participate in this study because as a subject matter expert, you possess a broad knowledge of ICNP®.

#### **Time commitment:**

If you consent to take part in this study your participation will include three or more Delphi Panel rounds estimated time to complete each round is one hour. However the estimated total time commitment is ten hours. Participating in this research will be from a location of your choosing.

#### **Inconvenience:**

Participating in this research will cause you the inconvenience of time spent participating in a Delphi study. Those who consent to participate will devote time to several Delphi panel rounds. The goal of this study is to reach a consensus, however all data will be analyzed between rounds and a synthesis will be presented in each round. If a consensus is not reached at the final round this will be included in the results section of the research

report. An optional debrief session facilitated by the principle investigator during the post research phase will be offered to all participants.

### **Risks**

There are no known or anticipated risks to you by participating in this research.

### **Benefits**

Potential benefits of participating in this research include:

1. A contribution to knowledge and understanding of contextual nursing practices.
2. A further benefit might be that substantiating nursing care that reflects certain values might serve the expansion of existing nursing terminology sets.

### **Voluntary Participation**

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw through submitting an email to [alewis@uvic.ca](mailto:alewis@uvic.ca) stating your intent to withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be destroyed within 10 days of the receipt of your request to withdraw and therefore not used as part of this research project in any manner or form.

### **On-going Consent**

To make sure that you continue to consent to participate in this research, the researcher will elicit your ongoing consent to participate at each researcher participant communication, in this case every Delphi panel round.

### **Participant's de-identified information:**

In terms of protecting your data the Delphi Panel that you are considering participating has the following characteristics:

1. De identified data-Participant information will be assigned a non-identifying numbering system. This system will remain in place throughout the research life cycle.
2. Several rounds of controlled feedback will proceed through the stages of data collection, analysis, and will be redistributed only by the principal researcher.
3. Debrief session with all Delphi study participants will be offered post completion of research phase II.

### **Confidentiality**

Safeguarding information and data collected during this study is of utmost priority. Specific measures to ensure the confidentiality and the security of all your personal information and data during the full extent of this research project will be prioritized as per the ethical obligations of University of Victoria HREB. However complete assurance of confidentiality cannot be guaranteed due to small number of subject matter experts in this specialized body of knowledge.

Upon the completion of the study and at the request from a participant this researcher shall return all contributing information received during the Delphi panel process upon receipt of written request within ten (10) days of such request.

All remaining contributing information in this researcher's possession after the completion of her work, will be securely archived for seven (7) years. Following that period of time the researcher shall provide a written certificate to participants regarding destruction processes.

Data collected during Phase II will be protected, stored and secured by the following means:

- Locked file cabinet
- Password protected computer and digital files. Compiled data such as the following will be protected and securely stored in a locked file cabinet:
  - Signed consent to participate forms.

### **Dissemination of Results**

It is anticipated that the results of this study will be shared with others in the following ways:

1. Published article
2. Presentations at scholarly meetings
3. University of Victoria Thesis portal-UVicSpace.

### **Disposal of Data**

It is important to state data derived from this research, is not intended to be used in future research.

All remaining contributing information in this researcher's possession after the completion of her work will be destroyed to protect the confidentiality of said information. Disposal of information will occur seven years after final analysis of all study data. This researcher shall provide a written certificate to participants regarding destruction within ten (10) days thereafter.

Raw data from this study will be disposed of following the publication of research reports and thesis submission. Electronic data will be erased and purged from all digital files; paper copies will be shredded. No secondary research will be conducted using

any data from this study.

**Contacts:**

Individuals that may be contacted at the addresses above regarding this study include:

Adrienne Lewis

Noreen Frisch

Karen Courtney

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or [ethics@uvic.ca](mailto:ethics@uvic.ca)).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

---

Participant Name

Signature

Date

*A copy of this consent will be left with you, and one copy is to be signed, scanned and sent to the researcher at [alewis@uvic](mailto:alewis@uvic).*

## APPENDIX I

### CONSENT TO PARTICIPATE PHASE II- NIC

#### **University of Victoria Participant Consent Form**

**Project Name:** Documenting nursing practice.

You are invited to participate in a study being conducted by Adrienne Lewis.

Adrienne Lewis is a graduate student at the University of Victoria in the department of Nursing and Health Information Science.

As a Graduate student, Adrienne Lewis is required to conduct research as part of the requirements for a degree in Nursing Science and Health Information Science. Her research is being conducted under the supervision of Noreen Frisch PhD., and Karen Courtney PhD. You may contact either supervisor by email at: nfrisch@uvic.ca., or court009uvic.ca respectively.

**Goals and Objectives:** The goal of this research is to document nursing interventions.

**Objective:** Consult with experts in the field of nursing languages sets to determine:

1. If nursing activities as presented in a case scenario can be coded in Nursing Intervention Classification N I C .

#### **Importance of this Research**

The importance of this research is that unique nursing practices are relevant in certain contexts. Documenting those activities in NIC would potentiate inclusion in the electronic health record representing the broad scope of nursing practices.

#### **Participant selection:**

You are being asked to participate in this study because as a subject matter expert, you possess a broad knowledge of NIC.

#### **Time commitment:**

If you consent to take part in this study your participation will include three or more Delphi Panel rounds estimated time to complete each round is one hour. However the estimated total time commitment is ten hours. Participating in this research will be from a location of your choosing.

#### **Inconvenience:**

Participating in this research will cause you the inconvenience of time spent participating in a Delphi study. Those who consent to participate will devote time to several Delphi panel rounds. The goal of this study is to reach a consensus, however all data will be analyzed between rounds and a synthesis will be presented in each round. If a consensus is not reached at the final round this will be included in the results section of the research

report. An optional debrief session facilitated by the principle investigator during the post research phase will be offered to all participants.

### **Risks**

There are no known or anticipated risks to you by participating in this research.

### **Benefits**

Potential benefits of participating in this research include:

1. A contribution to knowledge and understanding of contextual nursing practices
2. A further benefit might be that substantiating nursing care that reflects certain values might serve the expansion of existing nursing terminology sets.

### **Voluntary Participation**

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw through submitting an email to [alewis@uvic.ca](mailto:alewis@uvic.ca) stating your intent to withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be destroyed within 10 days of the receipt of your request to withdraw and therefore not used as part of this research project in any manner or form.

### **On-going Consent**

To make sure that you continue to consent to participate in this research, the researcher will elicit your ongoing consent to participate at each researcher participant communication, in this case every Delphi panel round.

### **Participant's de-identified information:**

In terms of protecting your data the Delphi Panel that you are considering participating has the following characteristics:

1. De identified data-Participant information will be assigned a non-identifying numbering system. This system will remain in place throughout the research life cycle.
2. Several rounds of controlled feedback will proceed through the stages of data collection, analysis, and will be redistributed only by the principal researcher.
3. Debrief session with all Delphi study participants will be offered post completion of research phase II.

### **Confidentiality**

Safeguarding information and data collected during this study is of utmost priority. Specific measures to ensure the confidentiality and the security of all your personal

information and data during the full extent of this research project will be prioritized as per the ethical obligations of University of Victoria HREB. However complete assurance of confidentiality cannot be guaranteed due to small number of subject matter experts in this specialized body of knowledge.

Upon the completion of the study and at the request from a participant this researcher shall return all contributing information received during the Delphi panel process upon receipt of written request within ten (10) days of such request.

All remaining contributing information in this researcher's possession after the completion of her work, will be securely archived for seven (7) years. Following that period of time the researcher shall provide a written certificate to participants regarding destruction processes.

Data collected during Phase II will be protected, stored and secured by the following means:

- Locked file cabinet
- Password protected computer and digital files. Compiled data such as the following will be protected and securely stored in a locked file cabinet:
  - Signed consent to participate forms.

#### **Dissemination of Results:**

It is anticipated that the results of this study will be shared with others in the following ways:

1. Published article
2. Presentations at scholarly meetings
3. University of Victoria Thesis portal-UVicSpace.

#### **Disposal of Data:**

It is important to state data derived from this research, is not intended to be used in future research.

All remaining contributing information in this researcher's possession after the completion of her work will be destroyed to protect the confidentiality of said information. Disposal of information will occur seven years after final analysis of all study data. This researcher shall provide a written certificate to participants regarding destruction within ten (10) days thereafter.

Raw data from this study will be disposed of following the publication of research reports and thesis submission. Electronic data will be erased and purged from all digital files; paper copies will be shredded. No secondary research will be conducted using any data from this study.

#### **Contacts:**

Individuals that may be contacted at the addresses above regarding this study include:

Adrienne Lewis

Noreen Frisch

Karen Courtney

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or [ethics@uvic.ca](mailto:ethics@uvic.ca)).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Participant Name	Signature	Date
<i>A copy of this consent will be left with you, and one copy is to be signed, scanned and sent to the researcher at <a href="mailto:alewis@uvic.ca">alewis@uvic.ca</a></i>		

## APPENDIX J

### PARTICIPANT INSTRUCTIONS: DOCUMENTING NURSING PRACTICE PHASE

#### II: INTERNATIONAL COUNCIL OF NURSING PRACTICE (ICNP®) DELPHI PANEL

#### **Background:**

This researcher has developed the following case scenario for your review. As you have now consented to participate in this Delphi panel, please follow “Round 1” instructions as below. The investigator anticipates a synopsis of findings of this round will be resubmitted to participants within five business days.

#### **Participant Instructions:**

##### **Step 1:**

Read through Case Scenario

##### **Step II:**

Name all nursing activities found in the case scenario in the table provided as per your subject matter expertise. Please add extra columns as needed.

##### **Step III:**

Return this document using “Documenting Nursing Practice Phase II- ICNP®.” the subject line to the confidential email address: [alewis@uvic.ca](mailto:alewis@uvic.ca)

#### **Step I:**

##### **Case Scenario**

##### **The patient:**

John Charlie is a First Nations elder. Belonging to the Sxcwepenc Nation, located within the Interior of B.C., he is a member of a large family. Of his seven children, only four are surviving. John has been living alone in a small home since his wife passed away 10 years previous. His home has wood and electric heat and he stays active chopping his own wood in the winter and doing his own cooking. Apart from home support once a week from the band home and community care program he remains independent enjoying regular family visits.

#### **History of Presenting Problem:**

Although he has experienced abdominal pain off and on for years, John had refused to see his doctor. However, yesterday his daughter came to bring John lunch and found him uncharacteristically still in bed at 11:00 am, she also noted upon arrival that the house was cold. Although he remained stoic, she pressed him as she noticed he was pale, sweating and unkempt. After a short while denying anything was wrong, John admitted he hadn't eaten due to increasing stomach pain for two days. His daughter then called 911

and phoned family to assist until the ambulance arrived.

### **Patient Presentation and Assessment:**

Upon admission, and following assessment by the Emergency Physician it was determined by a CT scan, and complete blood work up that John had evidence of long standing diverticulitis in the large intestine. While the CBC showed elevated WBC count, the CT scan ruled out the presence of abscess, fistula, obstruction or rupture. Determined to be low a surgical risk due to mild untreated hypertension (148/90) as John's only comorbid condition, he was admitted, intravenous Morphine (2 mg) and pre surgical IV antibiotics (Keflex 50 mg) were initiated by the emergency department nurses. Surgery was then scheduled the next day to resect a six-inch portion of the affected transverse colon. Feeling improved after receiving IV analgesics, John admitted to his family his long-standing abdominal pain.

### **Family supports:**

It was decided by the family that his oldest daughter Nila would remain with John during the days of recovery, however many family members were in attendance in the waiting room before his surgery. It was anticipated by the surgeon that John would be in the hospital for 7 days.

### **Hospital Kardex:**

Room: 324 Name: John Leslie Charlie Preferred Name: John DOB:	Allergies: KNA Drug: Food: Environment:	Plan: Mobilize as tolerated, plan for discharge 7 days post op	IV: Heparin lock
Primary Diagnosis:	Height: 5'9"	Diet: Day 4, Soft	
Secondary Diagnosis: Mild Hypertension	Weight: 184lbs	ADL's: Minimal assist Adaptive Equipment:	Activity: Up in chair Physio: Daily
Estimated Length of Stay: 7 days		Bladder: continent	
Surgery: Simple Bowel Resection Date: December 4,		Bowels: post operative Laxative x 8 days.	Drain/Dressing/Wound: Staples, Mepore

Religious/ Spiritual Affiliation : First Nations –	NOK: Daughter Nila Son: George		
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**Case Scenario:**

Following morning report and a review of her charts Abby, walks into room #324 to find her assigned patient John Charlie sitting up in bed. Noting that John appears comfortable Abby introduces herself making eye contact, “I am your nurse for today” she states and then asks permission to sit down in the chair beside the bed. While pulling the chair up beside the bed, Abby notices that although John initially made eye contact as he acknowledges her introduction, he soon looks away. Abby follows his cue, and does not attempt to hold his gaze. Initiating further conversation by acknowledging what brought John into the hospital, Abby inquires, “I know you have had a hard couple of days and I am interested in what has happened to you”. Abby reaches out to touch John’s hand briefly at the same time she touches her own chest and nods her head as he describes what has happened. “This has been tough for you” Abby suggests and that succeeds in eliciting more information from John. Continuing to follow his story, Abby nods her head indicating that she is interested and attentive. She then inquires “And how are you today?” Abby notes John, sighs and laughs softly, “Well I think I am on the mend now” and she nods her head and returns his tentative smile.

Standing up and approaching John’s bed only when he has finished describing his current condition and the conversation has slowed, Abby asks “Can I take your blood pressure, would that be okay?” As John nods his head, Abby intentionally starts with the least invasive vital sign measurement first; she takes his blood pressure (130/28) then pulse (72 and regular) and notes upon taking his temperature he is afebrile. Throughout performing these interventions Abby moves slowly continuing to seek his permission throughout the procedure by saying, “Ok now I will take your pulse and then temperature is that okay as well?”

Looking for ways to continue to create trust as she is performing vital signs Abby inquires, “Has your family been to visit?” Showing interest in his responses she notes John becomes more engaged in conversation when he speaks of his family. Abby asks further questions like, “Where are you from?” Continuing to show interest while she is learning more about John’s family, Abby also offers “My family also lives close by”. As Abby now senses even more ease in the conversation, she inquires “Is there someone in your community that could come visit you such as your traditional healer? We have the Okanagan room that we could reserve for you if that might work?” When John responds with “I will think about that” Abby moves the conversation forward to ask when would be a good time to change John’s abdominal surgical dressing. “John can I come back after breakfast and change your dressing? I’d like to hear more about your family as well” When John responds “yes” Abby thanks him for the visit and confirms she will be back after breakfast.

**Step II: Complete****Nursing Activity**

<b>Round 1:</b>	

**Step III:**

**Return this document within 2 business days using “Documenting Nursing Practice Phase II-ICNP®” in the subject line to [alewis@uvic.ca](mailto:alewis@uvic.ca).**

Thank you for your participation. The investigator will resubmit a synopsis of findings for your consideration in the next panel round in five days.

## APPENDIX K

### PARTICIPANT INSTRUCTIONS: DOCUMENTING NURSING PRACTICE PHASE

#### II: NURSING INTERVENTION CLASSIFICATION (NIC) DELPHI PANEL

##### **Background:**

This researcher has developed the following case scenario for your review. As you have now consented to participate in this Delphi panel, please follow “Round 1” instructions as below. The investigator anticipates a synopsis of findings of this round will be resubmitted to participants within five business days.

##### **Participant Instructions:**

###### **Step 1:**

Read through Case Scenario

###### **Step II:**

Name all nursing activities found in the case scenario in the table provided as per your subject matter expertise. Please add extra columns as needed.

###### **Step III:**

Return this document using “Documenting Nursing Practice Phase II- NIC” the subject line to the confidential email address: [alewis@uvic.ca](mailto:alewis@uvic.ca)

##### **Step I: Case Scenario-The patient:**

John Charlie is a First Nations elder. Belonging to the Sxcwepenc Nation, located within the Interior of B.C., he is a member of a large family. Of his seven children, only four are surviving. John has been living alone in a small home since his wife passed away 10 years previous. His home has wood and electric heat and he stays active chopping his own wood in the winter and doing his own cooking. Apart from home support once a week from the band home and community care program he remains independent enjoying regular family visits.

##### **History of Presenting Problem:**

Although he has experienced abdominal pain off and on for years, John had refused to see his doctor. However, yesterday his daughter came to bring John lunch and found him uncharacteristically still in bed at 11:00 am, she also noted upon arrival that the house was cold. Although he remained stoic, she pressed him as she noticed he was pale, sweating and unkempt. After a short while denying anything was wrong, John admitted he hadn't eaten due to increasing stomach pain for two days. His daughter then called 911 and phoned family to assist until the ambulance arrived.

### Patient Presentation and Assessment:

Upon admission, and following assessment by the Emergency Physician it was determined by a CT scan, and complete blood work up that John had evidence of long standing diverticulitis in the large intestine While the CBC showed elevated WBC count, the CT scan ruled out the presence of abscess, fistula, obstruction or rupture. Determined to be low a surgical risk due to mild untreated hypertension (148/90) as John's only comorbid condition, he was admitted, intravenous Morphine (2 mg) and pre surgical IV antibiotics (Keflex 50 mg) were initiated by the emergency department nurses. Surgery was then scheduled the next day to resect a six-inch portion of the affected transverse colon. Feeling improved after receiving IV analgesics, John admitted to his family his long-standing abdominal pain.

### Family supports:

It was decided by the family that his oldest daughter Nila would remain with John during the days of recovery, however many family members were in attendance in the waiting room before his surgery. It was anticipated by the surgeon that John would be in the hospital for 7 days.

### Hospital Kardex:

Room: 324 Name: John Leslie Charlie Preferred Name: John DOB: November 24, 1930	Allergies : KNA Drug : Food	Plan: Mobilize as tolerated, plan for discharge 7 days post op	IV: Heparin lock
Primary Diagnosis:	Height: 5'9"	Diet: Day 4, Soft	
Secondary Diagnosis: Mild Hypertension	Weight : 184lbs	ADL's: Minimal assist Adaptive Equipment:	Activity: Up in chair Physio: Daily
Estimated Length of Stay: 7 days		Bladder: continent	
Surgery: Simple Bowel Resection Date: December 4, 2014		Bowels: post operative Laxative x 8 days.	Drain/Dressing/Wound: Staples, Mepore
Religious/Spiritua l Affiliation: First Nations – Sxcwepenc Nation	NOK: Daughter Nila Son: George		

**Case Scenario:**

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**Step II: Complete****Nursing Activity**

<b>Round 1:</b>	

**Step III:**

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