Health Care Providers’ Perspectives of Providing Culturally Competent Care in the NICU

Leonora Hendson, Misty D. Reis, and David B. Nicholas

ABSTRACT

Objective: To examine the experiences and perceptions of health care providers caring for new immigrant families in the neonatal intensive care unit (NICU).

Design: Qualitative design using grounded theory methodology.

Setting: Two tertiary-level NICUs of two large metropolitan hospitals in western Canada.

Participants: Fifty eight (58) health care providers from multiple disciplines.

Methods: Health care providers were interviewed during seven focus groups. We recorded and transcribed focus group data. We analyzed transcripts via line-by-line coding, categorization of codes, concept saturation, and theme generation assisted through NVIVO software.

Results: Health care providers identified the nuanced construct of fragile interactions that is embedded within care of the new immigrant family in the NICU. During crisis, decision making, differing norms and beliefs, and language and communication are barriers that affected the fragile nature of interactions. During transition home, fragile interactions were affected by unintentional stereotyping, limited time for intangible activities, and lack of intuitive perceptions of the needs of new immigrant families. Health care providers employed caring and culturally competent strategies to overcome the fragile nature of interactions.

Conclusion: Within the premise of providing family-centered care is the concept of honoring cultural, ethnic, and socioeconomic diversity; it is imperative that culturally competent care be considered and implemented as a separate stand-alone aspect when caring for new immigrant families.

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Caring for infants and their families in the NICU presents a myriad of complexities for health care providers. Integrated within care delivery, the philosophy of family-centered care specifically honors ethnic, cultural, and socioeconomic diversity (Eichner, Johnson, & Committee on Hospital Care & Institute For Patient & Family-Centered Care, 2012). In the past several decades, Canada has experienced an increase in the number of new immigrants (Statistics Canada, 2012, 2013), which emphasizes the importance of providing culturally competent care in health care facilities. The NICU, with its unique patient population, acuity, and circumstances (birth, death, parental roles), is an area where further understanding of family-centered, culturally competent care is required for optimal care delivery.

Culture is defined as a set of values, beliefs, and norms that direct the thinking and decision making of a group (Leininger & McFarland, 2006). Cultural competence in health care is the ability of systems to provide care to patients with diverse values, beliefs, and behaviors and to tailor delivery to meet patients’ social, cultural, and linguistic needs (Betancourt, Green, & Carillo, 2002). Models for culturally competent care are available to assist health care providers in providing effective care (Betancourt et al., 2002; Campinha-Bacote, 2002; Leininger & McFarland, 2002; Purnell, 2002; Schim, Doorenbos, Benkert, & Miller, 2007). Although these conceptual models provide a basis for our understanding, they may not address the practical barriers health care providers face during direct bedside care for diverse populations.

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Limited research exists on the perspectives of health care providers on the provision of culturally competent care in the NICU.

Background
Limited research exists on care experiences in the NICU from a culturally competent perspective, and researchers have typically focused on the experience of the new immigrant family. Wiebe and Young (2011) interviewed 21 families from a broad spectrum of cultural backgrounds whose infants had been hospitalized in NICUs. A key finding of this study was the importance of the relationship between the parent and health care provider in developing confidence and trust in the care provided. The authors described respectful and appropriate communication, culturally responsive and accessible social and spiritual supports, and a welcoming and flexible organizational environment as important components of a relational, culturally congruent paradigm.

Hurst (2004) focused on Mexican American mothers’ experiences in the NICU and highlighted the importance of adequate resources to ensure family-centered care, including transportation and translation services. Cleveland and Horner (2012) illustrated the importance of cultural values such as sympatía (kindness), personalismo (formal friendliness), respeto (respect), familismo (devotion to extended family), and fatalismo (fate) when delivering care to Mexican American mothers. Among first-generation Chinese American parents, Lee and Weiss (2009) identified perceived incompetence, self-blame, blame from others, filial piety, lack of support, communication issues, and cultural differences as stressors for families. The use of parent buddy matching has been found to be effective in alleviating stress for non-English speaking mothers in the NICU (Ardal, Sulman, & Fuller-Thomson, 2011). Systemic supports such as a multicultural committees, needs assessments, and staff access to cultural interpreters have been identified as strategies to facilitate cultural competence (Bracht, Kandankery, Nodwell, & Stade, 2002).

Nicholas, Hendson, and Reis (2014) examined the experience of delivering care in the NICU to new immigrant families from the perspective of the health care provider. They identified aspects of connection and disconnection that health care providers experience on individual, institutional, and community levels and strategies that health care providers used to mitigate these influences.

We further examined the experiences of health care providers and their perceptions of providing culturally competent care to new immigrant families in the NICU at the individual level. Our specific research question was “What are the experiences of health care providers in providing care to recently immigrated families (within five years of immigration) whose children were admitted to the NICU.”

Methods
Because little is known about the phenomena of interest, we implemented an exploratory research design drawing on a grounded theory approach to generate theory (Corbin & Strauss, 2008; Hutchison, 2001). This allowed inquiry of the perspectives of participants with respect to relational interactions between health care providers and new immigrant families (Sbaraini, Carter, Evans, & Blinkhorn, 2011; Streubert & Carpenter, 2011). We intentionally selected mixed disciplinary focus groups as a data collection method to offer conversational depth through constructs initiated and explained by interdisciplinary staff (Nicholas et al., 2014). This approach offered an efficient means for thorough, reflective, and team-based exploration of professional experience. The University Research Ethics Board approved the study. All participants provided written informed consent prior to focus group commencement.

Participants
We employed purposive sampling to obtain a rich description of the phenomenon being explored from an interdisciplinary viewpoint (Patton, 1990). We recruited participants by advertising broadly in the NICUs (e-mail and posters) and by invitations (e-mail) to specific groups (social workers, physicians, and administrative leads) to ensure representation from all disciplines. We conducted the focus groups in two tertiary-level NICUs of two large metropolitan hospitals in western Canada. We arranged the dates and times of focus groups to accommodate different shifts (day, evening, and night) to mitigate any barriers to participation. All health care providers were invited to participate regardless of years of experience.

Fifty-eight health care providers participated in seven focus groups with three to 15 participants per group (Table 1). Of note, 62% of the participants were nurses (registered nurses and

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Table 1: Demographic Characteristics of 58 Health Care Provider Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
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<tbody>
<tr>
<td>Discipline</td>
<td></td>
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<tr>
<td>Registered Nurses (RN)</td>
<td>31</td>
<td>53</td>
</tr>
<tr>
<td>Registered Respiratory Therapists (RRT)</td>
<td>6</td>
<td>10</td>
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<tr>
<td>Registered Social Workers</td>
<td>4</td>
<td>7</td>
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<tr>
<td>Neonatal Nurse Practitioners</td>
<td>5</td>
<td>9</td>
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<tr>
<td>Neonatologists</td>
<td>3</td>
<td>5</td>
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<tr>
<td>Neonatal Perinatal Fellows</td>
<td>3</td>
<td>5</td>
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<tr>
<td>Administrative staff</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Registered dietitians</td>
<td>2</td>
<td>3</td>
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<tr>
<td>RN/RRT students</td>
<td>3</td>
<td>5</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Female</td>
<td>53</td>
<td>91</td>
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<tr>
<td>Male</td>
<td>5</td>
<td>9</td>
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<tr>
<td>Age (years)</td>
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<tr>
<td>18 – 25</td>
<td>5</td>
<td>9</td>
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<td>26 – 35</td>
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<td>40</td>
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<td>36 – 45</td>
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<td>46 – 55</td>
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<td>22</td>
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<td>56 – 65</td>
<td>4</td>
<td>7</td>
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<tr>
<td>Born in Canada</td>
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<tr>
<td>Yes, born in Canada</td>
<td>49</td>
<td>84</td>
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</table>

Table 2: Semistructured Interview Guide for Focus Groups

<table>
<thead>
<tr>
<th>Initial study questions</th>
<th>Prompt</th>
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<tbody>
<tr>
<td>1. Tell me about families that you have cared for who have</td>
<td>1. Tell me about your day-to-day interactions with family members?</td>
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<td>recently immigrated to Canada and who have been from different</td>
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<td>racial, cultural, or religious backgrounds from your own.</td>
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<tr>
<td>2. Can you recall a situation with a newly immigrated family</td>
<td>1. What made this encounter significant?</td>
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<td>that was significant to you?</td>
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<tr>
<td>3. What do you think it is like for newly immigrated families</td>
<td>2. What made a difference? What do you think could have made a difference?</td>
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<tr>
<td>who receive care in the Neonatal Intensive Care Unit?</td>
<td>3. What were the outcomes for the infant and family?</td>
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<tr>
<td>4. Tell me what lost in translation means to you.</td>
<td></td>
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<tr>
<td>Modified Questions Based on Emergent Analysis</td>
<td></td>
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<tr>
<td>1. Tell me about your experience with newly immigrated families</td>
<td></td>
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<td>in times of crisis such as life death situations.</td>
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<td>2. Does the sex of either the family member or the health care</td>
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<td>provider have a bearing on the interaction between health care</td>
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<td>provider and newly immigrated family member?</td>
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<td>3. Previous participants have requested more education on</td>
<td></td>
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<td>cultural sensitivity. What format would be most useful to you?</td>
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<tr>
<td>4. Tell me what lost in translation means to you.</td>
<td></td>
</tr>
</tbody>
</table>

Data Collection and Analysis

We employed a semistructured interview guide to allow participants to tell their stories and share their experiences. We collected and analyzed data concurrently. We used emerging themes to refine guiding questions in subsequent focus groups (Table 2). All three researchers facilitated focus groups. One researcher acted as the principal moderator as he was the most experienced focus group facilitator and had no previous relationship to the participants. The two other researchers provided clinical care in the NICU at the time of the study. All three researchers had had experience in the NICU in various roles (neonatologist, nurse practitioner, social worker). Every researcher kept personal written field notes of the focus groups and memos throughout the study.
Health care providers indicated that integrating diverse cultural practices increased complexity of care over the infant’s trajectory in the NICU from crisis to transition home.

After every focus group, all three researchers debriefed. This allowed for reflection, theory generation, concept identification, and modification of questions.

We recorded focus group data and transcribed them verbatim for analysis. After we had removed personal identifying information to maintain confidentiality and anonymity, transcripts underwent line-by-line coding, categorization of codes, concept saturation, and theme generation, assisted by the qualitative data analysis computer software NVivo 10. We analyzed data using open, axial, and selective coding (Corbin & Strauss, 2008). One researcher primarily conducted open coding through line-by-line review using the actual words and phrases of the participants. The two other researchers conducted open coding on selected portions of transcripts to ensure concurrence of coding. Coding continued within and across transcripts, and concept saturation was determined by an internal process of team review and reflection on the theoretical nature of the data. We conducted axial coding by reconstructing the data, seeking to understand the relationship of concepts and subconcepts. All three researchers conducted selective coding identifying the central construct and elements of fragile interactions. From this staged approach, we determined a theoretical framework, achieved consensus, and checked theoretical notions against data.

We demonstrated rigor through prolonged engagement, peer debriefing, triangulation, member checking, negative case analysis, and documenting an audit trail (Padgett, 2008; Tuckett, 2005). Prolonged engagement was evident in multiple focus groups at two sites, researchers’ facilitation of focus groups, and years of experience in this clinical area of the research team. The team engaged in peer debriefing through discussion about emerging findings. We achieved investigator triangulation by using a three-member research team from differing health care disciplines and with varying levels of experience in the NICU. We ensured member checking through presentations to the NICU staff at formal educational sessions. There was open discussion at the end of each presentation for clarification and confirmation of findings. We achieved negative case analysis through seeking examples of disconfirming data and variation relative to emerging codes and core concepts. We documented an audit trail through in-depth field notes. Accordingly, we explicated and justified study decisions and processes such that the concepts fit in the core category, the arguments “felt right,” and theory was consistent with the existing literature and the personal and clinical experience of the researchers and participants.

Results
Our analysis of health care providers’ accounts of caring for new immigrant families in the NICU revealed the construct of fragile interactions and the multilayered complexity of this relationship (Figure 1). Layers that were conceptualized were the influence of cultural, religious, or ethnic practices along the care trajectory; the medical status of the infant particularly during times of crisis and transition home; and strategies that health care providers utilized to mitigate the fragility of interactions (Figure 1).

Influence of Cultural, Religious, or Ethnic Practices
Health care providers described the influence of the new immigrant families’ cultural, ethnic, or religious practices as adding complexity to the care relationship: “It (cross cultural issues) just happens to be one more piece or burden which makes a fragile interaction worse or even makes a normal interaction fragile.” This quote exemplified for us the difficulty health care providers experienced related to cross cultural barriers that impacted on the relationship between the family and the health care provider. Particularly during times of crisis (imminent death, life altering decision making) the fragile interaction was worsened because of cross cultural misunderstandings. Less intuitively, during transition home (convalescence, discharge planning), the normal interaction was made more fragile because of cross cultural difficulties.

Crisis and Transition Home
During times of crisis, health care providers identified themes that heightened the fragility of interactions, including (a) the process of decision making, (b) differing norms and beliefs, and (c) language, communication, and understanding. During transition home, health care providers appreciated that the fragile nature of interactions was augmented by their own limitations
including (a) unintentional stereotyping, (b) time constraints to carry out intangible activities (such as communication and relationship building), and (c) a lack of intuitive perceptions of the family’s needs.

**Themes that Heighten the Fragility of Interactions During Crisis**

**Decision making.** Health care providers reported experiencing distress when dealing with new immigrant families around who should be making decisions and how decisions were made for infants who were gravely ill. In North American NICUs, parents are expected to play an active role in decision making. Alternatively, when new immigrant families relied on collectivistic, religious, or community advisers to make decisions, health care providers described a general sense of unease. One health care provider stated:

I remember this one particular case was really hard on staff because the person making the decision was not even here. It was a member of the community that came in on set days . . . . It was very difficult to grasp how this could be the decision-making person.

This was emphasized in situations where health care providers felt that continued intensive care was thought to be futile for the infant and the parents were not the key decision makers.

Health care providers described the family’s reference from their culture or country of origin contributing to the complexity of decision making. Health care providers discussed Western medical philosophies of care versus care where technologies may not be available or care may be delivered in a more paternalistic approach. Health care providers felt that when a family was not accustomed to being actively consulted in care, this contrarily created a lack of confidence on the part of the family in the care that was being provided. A participant stated:

[A patient’s mother] seemed to understand what I was saying but at one point she said,
“You are asking me what I should do? Don’t you know? . . . Well, don’t you know what you should be doing?”

Despite feeling helpless at times, health care providers described a strong obligation to follow the families’ wishes and respect their perspectives.

Differing norms and beliefs. Health care providers described instances of dissonance between health care providers and new immigrant families that were exemplified when there were differences in philosophies and practices regarding discontinuation of advanced care. A participant discussed the difficult emotional response this elicited for her:

The whole family was there, but mom could not be with the baby until it came home . . . . It was hard for me to deal with because I wanted her to be there with the baby . . . . I wanted her to hold that baby, and it ended up being dad that held when we were doing the compassionate care . . . . It broke my heart that mom was not a part of the process, absolutely broke my heart because I did not understand.

In this scenario, differences in perspective appeared to be deeply ingrained for the health care provider and the new immigrant family, rendering it difficult and morally jarring to accommodate another perspective.

Health care providers also described the difficulties new immigrant families appeared to have with expectations for survival in a Canadian setting, especially for extremely premature infants. In these instances new immigrant families expected to lose their infant because that was their frame of reference, and had to readjust to not only the survival of their infant but potentially long-term complications for their child. One focus group discussed this situation based on the following quote expressed by a participant:

I had one family who said, “You know, in our home, babies born before this gestation just die.” So when her baby was born at 24–25 weeks, she was terrified to even come up and see this baby because this baby was really not supposed to be alive, right? It took her weeks and weeks to really work that through.

Language, communication, and understanding. Participants consistently emphasized the impact of language and communication as a barrier to care. Even with the use of translators, interpreting the words and understanding the message in emotionally charged situations was often described as delicate and extremely poignant. In striving to provide the best possible care for families, health care providers expressed frustration in wanting but feeling unable to effectively communicate with new immigrant families. One health care provider stated:

It is frustrating because you want them to understand, but really they don’t. It is a battle. It takes a long time and you often wonder if they ever really get it or if they just accept that they don’t understand and hope that everyone is doing the right thing for their baby.

Another group exemplified this conundrum of care and potential miscommunication in a case of a dying infant and getting the message through to the family.

Sometimes it seems with the language barrier, the family comes back to the bedside and has no idea the baby is dying. I find that very hard on the bedside staff. We will read the note, and the note will have said the parents understand. Those are very hard and trying times for the staff, and you have to have these repetitive conversations where they just nod at you and you don’t know what to do.

Varying opinions about interpreter use and accessibility were expressed. Many health care providers felt that hospital-based interpreters were used only in crisis situations that further exacerbated the awkwardness of the situation by having an unfamiliar person present. Discussion occurred regarding the advantages and pitfalls of having other family or community members as interpreters. Despite attempts to ensure communication and understanding, health care providers acknowledged a sense of loss of “not doing a good job” and “not reaching the full potential of care” because of a lack of ability to effectively communicate with a new immigrant family.

Themes that Heighten the Fragility of Interactions during Transition Home

Unintentional stereotyping. Health care providers described at times feeling that they were
“writing off” a family by developing personal biases against a new immigrant family. In these instances, health care providers no longer tried to understand the cultural or situational circumstances of the family, creating tension, and perpetuating the fragility in the interaction.

These stereotyped views of families often related to visiting practices:

It was a daily struggle when this baby got better and everyday comments, “Well, this mom isn’t here. She is not doing this, she is not doing that.” But when you sat down and talked with her and you found that culturally they do not need to be there every day.

*Limited time to do intangible activities.* Nurses most commonly expressed that performing intangible tasks (tasks that are not easily measurable) that are required with new immigrant families to teach and ensure understanding was undervalued in NICU organizational structures. One focus group’s interactive dialogue included the following comment:

Then you [the nurse] will say “Oh I am so busy” and they [management] will say “Well what are you doing?” assuming you are not doing anything. You are just doing intangibles, something that is not measurable. You are talking, you are reassuring, you are helping, you are supporting, but you are not doing (with emphasis) anything.

The demands of action-oriented tasks and the added time required to build relationships with new immigrant families were viewed as imposing increased workload and emotional stress on health care providers, particularly nurses, yet a crucial aspect to providing appropriate and satisfying care to the new immigrant family. Whether it was because of language barriers or cultural differences, the time required to work with new immigrant families was reported to be longer to form relationships and teach families about the care of their infant. The following statement exemplifies this.

It is a struggle all the way through . . . . It takes a long time showing them, then explaining it to them . . . . try doing it because then they will get it in their own way . . . . I think it is just a slower process.

Intuitive Perceptions of the Family’s Needs. The ability to be perceptive to diverse cultural norms such as modesty, privacy, eye contact, and touch were described as having a significant influence on the health care provider’s ability to convey cultural sensitivity and respect. Health care providers described paying particular attention to aspects in their interaction with new immigrant families such as gender role differences, body covering (e.g., breastfeeding, skin-to-skin care), and modesty in the presence of the opposite sex. One health care provider stated:

Whether or not mom is comfortable being in the curtain pumping while people are coming and walking through and/or kangaroo caring with a bare chest and whether or not dad is comfortable with mom doing that. There are probably rules about that and so, if we do not know what they are, it is hard for us to be sensitive to them.

Strategies that Health Care Providers Utilized to Mitigate the Fragility of the Interaction

Enveloping (and moderating) the construct of fragile interactions were positive mechanisms that health care providers utilized in their interaction with new immigrant families (culture of caring). In addition to a strong foundational belief in the philosophies of family-centered care, health care providers identified mechanisms that assisted them in their abilities to encompass cultural aspects into care delivery.

The first mechanism identified was a seeking to understand another’s perspective. Health care providers described strong feelings of empathy for the new immigrant family. They described the importance of stepping back, being humble, and listening to families’ perspectives. In so doing, health care providers portrayed a sensitivity, responsiveness and reflexivity to the reality and experiences of the new immigrant family. One health care provider gave the following advice:

Find out what is important for that family: “Are you allowed to hold the baby or see the baby after the death? Are you allowed to help bath the baby? Who should be dressing the baby? What should the baby be wearing?” Every family is unique and every culture is unique and if we don’t know, we need to ask the question: “How do you need this to be for your family right now?”
Participants reflected on the need for the health care provider to be nonjudgmental and receptive to differences in life patterns and practices. Moreover, they recommended helping other team members to be reflective of their own perspective as well as that of the new immigrant family.

The second mechanism health care providers identified within the culture of caring was facilitating knowledge. Health care providers desired education about other cultures and religions as a starting point to care for new immigrant families. Education reportedly could be in the form of orientation, in-services, a manual of cultures, discussion following encounters with families, or even graduate families returning to the NICU to educate staff on their culturally related experiences and needs. At the same time, health care providers realized that families from different background are all unique and that people differ in their adherence to cultural norms, hence care needs to be individualized. Health care providers, nonetheless, described the potential benefit of having a baseline knowledge that could be built on and refined according to the individual and family.

Finally, health care providers identified relationship building as an aspect of care that was found to be rewarding. Regardless of the cultural background of the families, health care providers described the importance of forging genuine relationships, being respectful of all individuals, and empowering parents. One health care provider reflected:

I think that once you form the relationship and you have that continuity of care, I think that then you develop that trust and respect with those families and then, I think they are more apt to tell you what they need.

When attending to such relationship formation, health care providers reported feeling better able to do their job and respond to the needs of new immigrant families. Health care providers reported positive interactions with families as gratifying and motivating which in turn alleviated stresses in the NICU for the family and the health care provider.

Discussion

Relationships between health care providers and new immigrant families in the NICU are complex and nuanced, influenced by multiple factors, including the infant’s medical status (crisis and transition home), parent and family relationships, and the perceived importance of cultural or religious practices and philosophies for the family. This reciprocal relationship between health care provider and new immigrant family was exemplified by the construct fragile interactions. This fragility is experienced by health care providers and families, each with their own values and beliefs, and heightened by the infant’s medical status at times of crisis and transition home. To our knowledge, this is one of few studies conceptualizing the perspective of health care providers from multiple disciplines and over the trajectory of the infant’s course in NICU.

Schim et al. (2007) examined cultural competence from a relational perspective in a three-dimensional puzzle model of culturally congruent care. In this model, there are three layers to culturally congruent care: the provider, the client, and the desired outcome (culturally congruent care). The provider and the client come to the relationship with their own assumptions and propositions. At the provider level, the constructs that make up the puzzle include awareness, competence, diversity, and sensitivity (Schim et al., 2007). Wiebe and Young (2011) provided insight into the middle (client layer) of the culturally congruent care model related to families’ experience in the NICU. Although the work by Schim et al. (2007) and Wiebe and Young (2011) is foundational to our understanding of culturally congruent care, there is a gap in understanding the humanistic paradigm of the interpersonal relationships between health care providers and new immigrant families. The findings of this study, and the construct of fragile interactions, build upon available research and add to our understanding of what occurs at the interface between health care providers and new immigrant parents in the NICU.

The themes in this study related to times of crisis (decision making, differing norms and beliefs, and language, communication, and understanding) and transition home (unintentional stereotyping, limited time to do intangible activities, and intuitive perceptions of the family’s needs) could interface at the family-centered level. Hurst (2004) advocated for resources to facilitate the provision of family-centered care such as interpretation services and transportation. That being said, even with a background of family-centered tenets, organizations require a higher level of integration of culturally competent care to address deficiencies felt by health care providers and
immigrant families (Bracht et al., 2002; Wiebe & Young, 2011; Fletcher, Rimsza, & the Committee on Pediatric Workforce, 2013). This was illustrated in this study through various examples. Health care providers who participated in this study came from the perspective that decisions are made collaboratively between the health care team and the family. Among some immigrant families, decision making might reflect a variety of orientations such as collectivism or paternalism, which may be incongruent to the ethos of a family-centered care setting. Finding amenable means of navigating these dynamics are important because respect and communication are key components of family-centered care, but may be difficult with cultural and language barriers.

Although various models provide a framework for delivering culturally competent care, these are often not naturally woven into the organizational or individual provision of care for immigrant families. The process of cultural competence is a model that requires the health care provider to continually strive to become culturally competent to work effectively within the cultural context of the individual, family, and community (Campinha-Bacote, 2002). The Purnell (2002) model for cultural competence provides a framework and a schematic with metaparadigm-based concepts of global society, community, family, person, and health, and 12 cultural domains. In pediatric settings, small studies among nurses (Berlin, Nilsson, & Törnkvist, 2010) and physical therapy students (Hayward & Charrette, 2012) using cultural competence frameworks by Purnell and Campinha-Bacote, have demonstrated some evidence of the effectiveness of cultural competence in care as demonstrated by an enhancement in the nurses and physical therapy students' professional attitude and awareness. Preyde (2007) and Ardal et al. (2011) describe a parent buddy system whereby ethnically diverse mothers of preterm infants in the NICU were matched for language, culture, ethnicity, and infant characteristics with a parent volunteer who had previously had an infant in the NICU. Parents reported greater confidence in parenting, understanding of the medical condition of their child, and quality of listening support. Merritt (2013) describes a transcultural nursing model to assess, understand, and communicate with families of Chinese descent in the NICU so as to develop a trusting, supportive relationship.

Within the layer, culture of caring, the empirical strategies that health care providers in this study prescribed to buffer the fragile nature of interactions were components of culturally competent care. Health care providers described ways in which they were able to adapt their practice and philosophy to incorporate provision of care for the family’s extraneous circumstances. These included seeking to understand another’s perspective (cultural awareness and cultural encounter), facilitating knowledge (cultural knowledge), and building collaborative relationships (cultural skill, motivation, and awareness) (Campinha-Bacote, 2002).

**Limitations**

There are several limitations in this study. First, only health care providers were interviewed, and therefore this study portrays a one-sided perspective of a dyad consisting of those who provide as well as receive care. Although new Canadian families’ perspectives are presented, they are described from the perspective of the health care providers. A strength of the study is the interdisciplinary nature of the focus groups. Notably, nurses (registered nurses and neonatal nurse practitioners) constituted the majority of participants in this study. Nurses provide the vast majority of direct bedside care, developing relationships with families, and advocating on behalf of families with all other professions. A second limitation in this study was the sampling technique of focus groups with voluntary participation. As with any focus group, more vocal members influenced discussion. A third limitation is the characteristics of the health care providers interviewed. Participants were from two large metropolitan hospitals from western Canada. Immigration policies, economic factors, and institutional practices vary in other regions nationally and internationally.

**Implications for Future Research**

In this study, we addressed the complex interpersonal relationships and interactions that occur between health care providers and new immigrant families in the NICU. More research is required to further explore the broadening importance of culturally competent care in health care, the experiences of front-line staff in providing this care, and the experience of the new immigrant family particularly in critical care environments such as NICU. A second phase of this study examining the experience of the new immigrant family is currently underway.
In the global world in which we practice, there is an obligation to amplify the cultural competence of health care providers to optimize care delivery.

Conclusion

Culture is dynamic, as is the experience of the infant and family and their navigation in the NICU. Within the crucible of the NICU, we require a framework to understand the interpersonal and relational influences between health care providers and new immigrant families to optimally practice culturally competent family-centered care. The perspectives of health care providers in this study may assist nurses and health care providers in understanding pivotal points of vulnerability and relational fragility experienced by health care providers and new immigrant families. This knowledge may facilitate the establishment of more collaborative, effective relationships between health care providers and new immigrant families in the NICU.

We challenge that culturally competent care should not be a “tag-along” to family-centered care; nor should it be confused with family-centered care. Culturally competent care and family-centered care are two distinct processes and philosophies that are aligned in their emphasis on identifying the patient and family as unique, and in delivering the highest quality of care. In the global and internationally mobile world in which we practice, there is an obligation to amplify the cultural competence of health care providers and organizations in order to optimize care delivery.

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REFERENCES


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