

Preparing a Culturally Competence Nursing Workforce

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Abstract

Despite numerous efforts to create a culturally competent nursing workforce, there continues to be a sense of urgency to prepare nurses who can meet the healthcare needs of diverse populations. This study responds to that urgency by uncovering care practices that support faculty as they prepare culturally competent students within baccalaureate and graduate nursing programs in public and private universities serving rural and urban areas throughout the United States. These generic and professional care practices are grouped into four themes to give nursing educators and administrators specific, evidenced-based recommendations they can use to initiate or extend school of nursing efforts to produce a culturally competent nursing workforce. The findings also demonstrate the value of extending the Culture Care Theory and ethnonursing research method beyond clinical environments and into the nursing education setting.

Keywords: culture care theory, ethnonursing research method, nursing education

Nurse educators worldwide are compelled to prepare nurses who can meet the healthcare needs of diverse individuals, families, communities, and nations (International Council of Nurses, 2012; Transcultural Nursing Society, n.d.). In addition, several national organizations call for preparing a culturally competent nursing workforce through educational training (American Association of Colleges of Nursing [AACN], n.d.; American Nurses Association, 1991; National League for Nursing, n.d.; Institute of Medicine, 2010). Becoming culturally competent helps nurses effectively care for patients from a variety of cultural backgrounds (Levine, 2009). Recently published literature clearly shows that engendering cultural competence in nursing students is vital in reducing patient care disparities in the modern healthcare landscape (Calvillo et al., 2009; Lancellotti, 2008; Lowe & Archibald, 2009).

Current research has examined many aspects of preparing a culturally competent nursing workforce. While the terminology seems to be slowly migrating toward a universal set of terms, there is still little consensus about what the blanket of cultural competence embodies (Clark et al., Sumpter & Carthon, 2011; Bren-

nan & Cotter, 2008). Generally, authors have described cultural competence as the attitude, knowledge, and skill nurses use to care for diverse people (The California Endowment, 2003). Cultural competence is a process, and the culturally competent nurse strives throughout his/her career to continue to develop cultural knowledge and provide culturally competent care. For patients, such care is satisfying and meaningful, fits with their daily lives and needs, and helps them achieve health and well-being or face illness, disabilities, or death (Andrews, 2012; McFarland & Leininger, 2002; Leininger, 2006a).

While some studies demonstrate an improvement in nursing faculty confidence and preparedness to teach cultural competence, many still are not prepared (Kardong-Edgren, 2007; Mixer, 2011; Nairn, Hardy, Harling, Parumal, & Narayanasamy, 2012; Starr, Shattell, & Gonzales, 2011; Wilson, Sanner, & McAllister, 2010). Research demonstrates that nursing students' cultural competence continues to be a work in progress with several educational strategies being used to promote this ability. Cultural content has been provided as a single unit or module, incorporated throughout a course, or integrated throughout the curriculum. The AACN (n.d.), a national organization for baccalaureate- and higher-degree nursing programs, has prepared an extensive toolkit for educators to promote cultural competence. Clinical assignments among diverse populations within one's region or through domestic/international cultural immersion experiences also are used (Amerson, 2010; Kardong-Edgren & Campinha-Bacote, 2008; Larsen & Reif, 2011; Lui, Mao, & Barnes-Willis, 2008; Sagar, 2012).

Despite these efforts, further research is needed to document and disseminate strategies that incorporate culture into nursing curricula, prepare faculty to teach cultural care, and prepare culturally competent nurses. The original study was a first step in addressing these research gaps (Mixer, 2011, 2008). This study

builds upon that work by broadening the participant pool and environmental context, thereby expanding the transferability of the research findings. The purpose of this study was to discover the nursing faculty care practices that support faculty as they prepare culturally competent students within baccalaureate and graduate nursing programs in public and private universities that serve rural and urban areas throughout the United States. This study used the following three research questions. In what ways do nursing faculty care expressions, patterns, and practices influence teaching culturally competent care? In what ways do worldview, culture, social structure, and work environment influence nursing faculty teaching culturally competent care? In what ways does nursing faculty teaching culturally competent care influence their health and well-being within the context of the school of nursing and university?

Theoretical Framework and Research Methods

This study was guided by the Culture Care Theory (CCT) that purports that nurses can only be culturally competent when they know the care expressions, patterns, and practices of people in their care (Leininger, 2006a). Traditionally used with patients and families, this unique application of the theory offered a comprehensive and holistic means to understand the factors influencing faculty as they teach culturally competent care. The theory includes three action and decision modes, which guided the application of research findings (Leininger, 2006a).

This study employed the qualitative ethn nursing research method, which was derived from ethnography and developed for use with the CCT. Ethn nursing is a naturalistic, open discovery method used to systematically understand and interpret people's meanings, experiences, and lifeways: what people do and how they are in the world. The goal of pairing the CCT and the ethn nursing method is to discover generic (folk) and professional care prac-

tices that promote health and well-being, and are congruent with people's values, beliefs, and practices (Leininger, 2006b). The ethn nursing principles that guide the researcher include active listening and maintaining an open discovery process and genuine learning attitude. The researcher remains an active learner by being willing to learn from the people, demonstrating respect, and avoiding ethnocentric bias. The method's open, inductive process of discovering and interpreting peoples' care meanings and experiences made it effective for discovering—directly from the faculty themselves—the practices that they believe help them teach cultural care (Leininger, 2006b).

In contrast to operational definitions, the ethn nursing method allows orientational definitions to evolve during a study (Leininger, 2006b). The following orientational definitions evolved inductively from open-ended interview data. *Generic care* describes the care practices faculty learned from their families, friends, and colleagues. *Professional care* is learned in formal nursing education and through professional modeling and mentoring. *Faculty care* is caring for students, one another, and oneself. *Faculty health and well-being* includes being able to perform one's daily roles related to teaching cultural competence, and embracing each other's cultural similarities and differences, providing respect, and engaging in mentoring/co-mentoring (Mixer 2011).

The institutional review board gave approval for the study. Purposive sampling was used to recruit nursing faculty throughout the United States from undergraduate and graduate programs and public and private universities to participate in the study. Participants volunteered, provided consent, and then their data was de-identified through coding. Data were collected over one year through unstructured, open-ended interviews conducted during face-to-face meetings and phone calls. All interviews were audio recorded and transcribed. To help ensure consistency, each researcher used an

interview guide (Table 2) for every interview which was developed by the research team based on culture care theoretical concepts and the domain of inquiry. Interview transcripts and field notes were coded independently and research team members met regularly to compare transcripts and reach a consensus on coding decisions. Data analysis was guided by the CCT and data were analyzed using the four phases of ethn nursing data analysis: 1) collecting and describing raw data; 2) identifying and categorizing faculty narratives similarities and differences; 3) analyzing care patterns and contexts; and 4) synthesizing major care themes, theoretical formulations, and implications for nursing education (Leininger, 2006b).

Using Leininger's qualitative criteria for ethn nursing studies helped ensure the rigor of the results. These criteria are credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability (Leininger, 2006b). Interviews were conducted until data saturation occurred. Interview transcripts and field data were described, categorized, and then analyzed for meaning-in-context and care patterns which led to discovering major themes. Each theme and care pattern can be traced back to participant quotes (raw data) to provide an audit trail and ensure credibility. Participants confirmed research findings during follow-up phone calls and emails.

Results

Demographics

Purposive sampling was used to recruit 16 research participants—15 females and one male—from 11 states including Alaska and states in the Northeast, Midwest, Southwest, and Southeast regions. One participant was African American and 15 were Caucasian with a variety of self-identified backgrounds. For example, participants described their cultural heritage in the following terms: "Anglo," "British," "Czech," "Swedish," "Irish," "Polish," "Lithuanian," "German," "Scottish," "Italian," "South-

Theme	Universal and Diverse Patterns
Theme 1–Teaching culturally competent care is complex.	• Teaching culturally competent care requires understanding of the covert and explicit aspects of culture. • Faculty taught culturally competent care in the classroom, online, and in clinical contexts. • Diverse Pattern: some faculty taught culturally competent care using an organizing framework and others did not.
Theme 2–Faculty care is embedded in spiritual values, beliefs, and practices	• Everyone has a spiritual dimension. • Diverse pattern: some faculty described open spirituality while others expressed their spirituality based on their religious faith
Theme 3–Faculty provided generic and professional care to nursing students to promote their cultural competence and success.	• Respect for students • Honoring students’ multi-dimensional culture • Faculty generic (family) and professional (mentoring and modeling) care
Theme 4–Care is essential for faculty’s health and well-being in order to teach culturally competent care.	• Leadership • Respect • Reciprocal caring • Self-care

Table 1: Major Research Findings: Nursing Faculty Care Practices that Contribute to Preparing Culturally Competent Students.

ern-American,” and “Euro-mixed-mutt.” Eight participants were tenured faculty and eight were tenure-track, clinical, or part-time faculty. They ranged in age from 39–71 years with an average age of 56. The faculty taught at 10 public and six private institutions. Eleven institutions were in urban settings, two in rural settings, and three served both rural and urban communities. Faculty self-identified their faith beliefs as spiritual (2), Unitarian (2), pagan (1), and Christian of varying denominations (11). The Christians used such terms as “raised in Methodist tradition,” “Baptist,” “Lutheran non-practicing,” “Catholic-non-affiliated,” “Christian,” and “Protestant” to describe their faith beliefs.

Faculty participants’ nursing experience ranged from 14–50 years with an average of 34 years. Their teaching experience ranged from 1–37 years with an average of 18 years. Formal education varied with eight participants holding a PhD (six in nursing), one a DNP, and sev-

en with MSNs (two currently working on nursing PhDs). Four out of 16 participants had taken a formal transcultural nursing education course or workshop. Fourteen of 16 had taught culture, diversity, transcultural nursing, or cultural immersion experiences.

Major Research Findings

The researchers extrapolated four major themes with universal and diverse patterns (Table 1). As the themes and patterns are discussed, salient participant quotes are provided to illustrate faculty perspectives and provide deeper meaning to the research data.

Theme One—Teaching culturally competent care is complex. Three patterns emerged within this theme. The first was that *teaching culturally competent care requires that faculty understand the covert and explicit aspects of culture*. This pattern was a universal finding for all participants. One faculty stated, culture is “Not just my race or

my faith, there are a lot of things that make me who I am... educational level, my age, my marital status... my personal mission statement... and I think the students know that I value and am truly interested in the things that make them who they are." Participants stressed the importance of helping students conduct cultural assessments. One faculty stated, "... [a nurse needs to] be a great detective and find out what is going to work best... to support that client to move ahead for better health... and care."

The second pattern of this theme was that *faculty taught culturally competent care in the classroom, online, and in clinical contexts*. While most participants felt that cultural concepts should be integrated throughout the curriculum, in many cases, these concepts were taught either in a single course lecture or as one participant described, in a "hit or miss" fashion. One program offered an elective transcultural nursing class while another required such a course.

Culturally competent care was explicitly taught through modeling in both classroom (face-to-face and online) and clinical contexts. Faculty described learning culturally competent care through "modeling" and using the same strategies in their teaching. They reported using large and small classroom discussions, debates, and clinical reasoning strategies such as case studies.

When teaching culturally competent care online, faculty used a variety of technologies (e.g. web-based content, videoconferencing, YouTube videos, or online presentations). Some faculty valued online teaching while others did not. Most felt they needed "specialized training" to teach effectively online. Some stressed the importance of creating a safe online learning environment where students feel "less guarded" and faculty "listen" to students.

In the clinical setting, most participants assigned students diverse patients, while others identified "missed opportunities" for diverse clinical placements. Many also engaged in cultural immersion experiences, both domestic

and international, which place students "outside their cultural norms". One faculty stated, "I think it is essential for every nursing student to have an experience as a minority." Another participant spoke about "integrating caring... into simulation experiences" as another means to broaden students' clinical learning and teach these essential concepts.

A diverse pattern of this theme was that *some faculty taught culturally competent care using an organizing framework and others did not*. Faculty reported using nursing theories or models by "Leininger," "Campinha-Bacote," "Purnell," "Newman," "Roy," and "Boykin and Schoenhofer." Findings revealed that faculty who held or were earning doctoral degrees described the importance of using an organizing framework to guide their teaching. The faculty who did not use an organizing framework described teaching based on their clinical experience.

Theme Two—Faculty care is embedded in spiritual values, beliefs, and practices. Faculty care was discussed within the context of caring for patients, families, communities, students, and one another. The universal pattern was that everyone has a spiritual dimension. The diverse pattern was that *some faculty described an open spirituality, while others expressed spirituality based on religious faith*. All faculty, regardless of how they classified their spirituality, reported having a spiritual foundation for their care. One participant described herself as a "Universalist" while another shared that her care was embedded in her belief in "humanity and goodness." One self-identified "Christian" participant referred to her belief in the "Golden Rule," while another shared that her faith is "an integral part of who I am."

Theme Three—Faculty provided generic and professional care to nursing students to promote their cultural competence and success. Three universal patterns were revealed within this theme: *respecting students, honoring students' multi-dimensional culture, and faculty providing generic and professional care*. Faculty de-

Teaching Culture Care in Nursing Faculty Open Inquiry Guide	
Ethnodemographics:	
Name:	Spiritual / Philosophical Background:
Informant #:	Cultural Background / Ethnic Orientation:
Gender:	Undergraduate Degree(s) & Institution(s):
Age:	Graduate Degree(s) & Institutions(s):
Place of Residence: Previous places of residence: Geographic location of universities:	Languages Spoken:
Number of Years as an RN: Number of Years Teaching Nursing: Total: and at Current University: Formal course / workshop in TCN:	Date(s) of Interview(s):
Ethnohistory: Tell me about your nursing career. Tell me about your teaching career and how you came to teach nursing.	
Worldview: Tell me how you view the place of nursing / nursing education / teaching about culture care in the world today in your country, state, and city.	
Care: 1. Tell me about how you view the construct of care in nursing. 2. Tell me about the care you have given to your students in the classroom and / or clinical settings. 3. Describe your source / roots of caring. 4. As nurses, we all gave direct client care at one time (body, mind, and spirit), how do you bring these concepts of care into the classroom? 5. How do you teach students to care? (What design, content, teaching strategies do you use?)	
Generic/Family/Folk Care: 1. Describe what you learned about caring from your family. 2. Do you ask students to examine their own generic care backgrounds? 3. How do you teach students to care for one another? How might this be expressed in the clinical setting in caring for people?	
Professional Care: Describe how you were taught in your initial nursing education and about culture care.	

Table 2: Interview guide (continued on next page)

Cultural Values, Beliefs, and Lifeways:

1. Tell me about your cultural background.
2. What values and beliefs do you feel are most important for providing/teaching nursing care?
3. What cultural groups are represented among the students, faculty, staff, and peers at your institution?

Health (Well-being):

1. Have you ever thought about the idea of health/well-being as it is applied to a faculty or an institution?
 - How would you describe a healthy institution, a healthy school of nursing, a healthy nursing faculty?
 - How would you evaluate your health and well-being in your role as a faculty member?
2. Tell me about care that nursing faculty, staff, or peers may have given you. Tell me how this care affected your health and your ability to teach/teach culture care and conduct scholarly activities.
3. Describe how your ability to teach nursing students is influenced by your health/well-being.

Environmental Context**Educational Factors**

1. Describe how you became knowledgeable about caring for diverse people.
2. Describe the culture knowledge you feel is essential for nursing students to have.
3. Tell me about teaching strategies you have used to teach about culture
 - Describe the types of clinical experiences nursing students have.
4. Describe if/how you consider the cultural background of your students.
 - Describe if/how your cultural background influences your teaching.
5. Are there any particular theories (nursing, education, or your own) you use to guide your teaching about culture/care?
6. Regarding teaching about culture/care:
 - What are you doing well?
 - What needs further improvement/refinement?
 - Do others need to be involved in this process (e.g. administration, colleagues, etc.)?
 - Describe any barriers or facilitators you experience in teaching about culture.

Technological Factors

1. How does technology facilitate you teaching about culture/care?
2. What technology seems to be most essential in terms of teaching culture/care in nursing?
3. Are you teaching in an on-line environment? If so tell me about how care is taught/incorporated in this environment.

Political Factors

1. Tell me how politics affects your teaching of culture and care.
2. What is the importance of considering culture at this institution?
 - Give an example of what you view the university is doing well in relation to cultural diversity and what you believe is an area for growth.
3. Tell me about how teaching students about culture is viewed among faculty.
4. Do other organizations influence your teaching about culture?
5. Describe requirements of accrediting organizations.

Economic Factors

1. Describe how financial resources affect your ability to teach about culture/care.

Table 2: Interview guide (continued from previous page and continued on next page)

<u>Kinship/Social Factors</u> 1. Tell me about teaching students about family care/culture care. 2. Describe your professional/collegial relationships and how these relationships help or hinder you teaching culture care. 3. Give an example of how faculty might care for one another. <u>Religious Factors</u> 1. Tell me about your source of spiritual strength. 2. Describe any relationship your religious/spiritual beliefs/background has on teaching culture care. 3. Describe how students learn about the spiritual/religious dimensions of culture care.
Summary Questions 1. Is there anything else you want to tell me about your experience of culture/care/Transcultural nursing? 2. Is there anything else you want to share with me before we close? 3. I would like you to call/e-mail me if you think of anything you would like to add. 4. After I have had a chance to review this information, I would like to call/e-mail you back to clarify data.
This guide was adapted from the following two sources: Leininger, M. (2002). Leininger’s suggested inquiry guide for use with the sunrise model to assess culture care and health: Culture care assessments for congruent competency practices. In M. Leininger & M. R. McFarland (Eds.), <i>Transcultural nursing: Concepts, theories, research & practice</i> (3rd ed.) (pp. 117–143). USA: McGraw-Hill. Leininger, M. (2006). Ethnonursing: A research method with enablers to study the theory of culture care. In M. Leininger & M.R. McFarland (Eds.), <i>Culture care diversity & universality: A worldwide nursing theory</i> (pp. 43–81). New York, NY: National League for Nursing Press.

Table 2: Interview guide (continued from the previous two pages)

scribed the importance of respecting students by honoring and appreciating their similarities and differences, and demonstrating an “accepting” attitude. Faculty also recognized the ethnic diversity among their student populations. Some described great diversity while others named one or two students of a particular ethnic group. Participants emphasized the need to recognize not only student’s ethnic background but also additional cultural factors such as age, gender, and socioeconomic status.

Faculty promoted student cultural competence through their generic and professional care actions. Faculty reported that their “parents” and extended family members taught them the values, beliefs, and actions that serve as the foundation of their own generic care practices. The “Golden Rule” was again identified as the basis of caring for students. One participant explained that he “treats students the way [I] would want to be treated.” Participants described initially learning professional care

through formal nursing education and later through “modeling” and “mentoring”. In turn, modeling and mentoring were the most often described methods for teaching culturally competent care. Another participant described that nursing’s “strong sense of community” served as the foundation for her professional caring. Interestingly, one participant discussed the lessons she learned about professional caring through studying “nursing’s historical legacy”.

Theme Four—Care is essential for faculty’s health and well-being in order to teach culturally competent care. This theme is supported by the following four patterns: *leadership*, *respect*, *reciprocal caring*, and *self-care*. This caring occurs among faculty and administrators within the school of nursing and the university. Participants described the importance of having “strong” and “supportive” leadership who valued culture and supported teaching students to be culturally competent. Shared governance models, “team effort[s],” and “continuing edu-

cation funds” were given as examples of caring leadership. Faculty described being dependent on their leaders to provide financing for cultural immersion experiences. Several participants stated that, while administrators spoke of supporting such projects, the funding was often “inadequate”.

“Respect” was unanimously described as a foundational value essential for a healthy work environment. Faculty expressed that valuing faculty differences contributes to collegial relationships, and models a culturally competent workplace for students.

Reciprocal caring was described with conflicting perspectives. Some participants felt such caring was universal among their faculty while others did not. Many reciprocal caring examples came in the form of support given during a crisis. One participant recalled supporting a colleague and her family at the time of her death by “sitting at the bedside” and “engaging in prayer.” Reciprocal caring was also described as “honoring” life events such as weddings, childbirth, and professional accomplishments (promotions, tenure, and doctoral degree completion). Conversely, some participants described small groups in their schools of nurses who engage in non-caring behaviors such as forming “cliques” and “acting like prima donnas.”

Self-care was described at the individual and institutional levels. Individually, faculty managed stress and workload demands by seeking healthy “nutrition”, adequate “rest”, spiritual support, and emotional encouragement. Institutionally, some faculty described the adaption of physical spaces. For example, one school of nursing designed their building using “Fung Shui principles” with gardens and meditation areas. Other faculty described using institutional “exercise facilities”.

In summary, teaching nursing students to become culturally competent is a multifaceted process. The strategies revealed in these findings—promoting cultural knowledge, supporting a spiritual dimension, and caring for

students, others, and self—can be used as an important step, or even a foundation, in this process.

Discussion

Limited research has examined the faculty care expressions, patterns, and practices that facilitate cultural competence in nursing students. This study used the ethnonursing research method and CCT to discover, document, and describe the care values and practices participants used to model and teach culturally competent care. Study findings may be transferable to faculty who teach in undergraduate and graduate nursing programs in public or private institutions in urban and rural settings. While this study was conducted with nursing faculty in the United States, the findings may be useful to nurse educators, throughout the globe, who strive to prepare a culturally competent nursing workforce.

Evidence-based Recommendations

Study recommendations are framed using two of Leininger’s three culture care action and decision modes. The first mode, culture care preservation/maintenance, refers to those supportive professional care actions and decisions nursing faculty should maintain to facilitate student cultural competence. The second mode, culture care accommodation/negotiation, refers to actions and decisions that help nursing faculty negotiate new care strategies to promote student cultural competence (Leininger, 2006a, p. 8.).

The researchers offer the following evidence-based recommendations based on the analysis of studying findings. For culture care preservation/maintenance, faculty are encouraged to preserve their spiritual dimension, engage in reciprocal caring, and combine their generic (family) and professional (mentoring and modeling) care actions. For culture care accommodation/negotiation, faculty are encouraged to use an organizing framework (theory or

model) to teach and integrate cultural concepts throughout the nursing curriculum. Faculty also are urged to negotiate for leadership and financial support to initiate or continue student cultural immersion experiences.

Spirituality. The faculty in this study each described that caring was embedded in their spiritual values, beliefs, and practices. Similarly, spirituality in the workplace was described as an element that fostered community and respect for others' beliefs and traditions (Kowalchuk, 2010). Awareness of the role spirituality plays in the foundation of one's caring is useful for faculty as they help students develop culturally competent care practices.

Methods for teaching culturally competent care. The findings that only some faculty taught using an organizing framework and that culture is explicitly taught through modeling also were found in the original study (Mixer, 2011). Using an organizing framework ensures that culturally competent care is taught from a holistic perspective and incorporates evidence-based knowledge rather than relying solely on faculty's clinical experiences. This study revealed that faculty learned caring from their family of origin and that these roots of caring were a powerful influence on the generic and professional care they expressed to students. When faculty modeled generic and professional care, they helped promote student cultural competence and success. In a study of 243 BSN students, faculty modeling was purported to be essential in students learning to care (Livsey, 2009). In another study of 74 nursing faculty from nine countries, researchers urged faculty to move beyond modeling and explicitly teach professional values and attitudes (Haigh & Johnson, 2007). The researchers add that these values and attitudes are those that foster cultural competence.

Healthy work environment. Consistent with this study's findings, a healthy academic work environment was found to include a supportive, inclusive atmosphere where faculty care for one another and students, and are valued and

supported, especially in achieving tenure and promotion (de Leon Siantz, 2011; Keuhn, 2010). Academic leaders are charged with cultivating a healthy work environment and providing resources to develop cultural competence in faculty and students.

Constructs

Care constructs, as described in the CCT are the meanings of care as articulated by individuals and cultural groups. A nurse that understands an individual's deep-held care meanings is better equipped to meet that person's unique needs. In this study, respect was found to be the most important care construct for faculty teaching students to be culturally competent. Participants discussed showing respect for students and one another. Research shows that respect is the most valued and frequently identified care construct (Leininger, 2006c; Morris, 2012; Schumacher, 2010). Respect also was found to be essential for promoting a productive teaching/learning environment (Clark, 2008) and teaching cultural competence (Mixer, 2011).

Limitations

The findings of the study should be considered in light of several limitations. While this study expanded the participant pool from the original study, all of the participants were from the United States. Future studies of nursing schools in other countries would be needed to validate the results for further dissemination. Research team members worked to achieve interview consistency by using one interview guide. However, having four researchers conducting interviews may have resulted in differences in how the questions were refined. To combat this phenomenon and help ensure consistency, all research team members participated in team meetings throughout data collection and collaborated on the data analysis and interpretation.

Conclusion

While schools of nursing have made significant progress toward creating a culturally competent nursing workforce, there continues to be a sense of urgency to prepare nurses who can meet the healthcare needs of diverse individuals, families, communities, and nations. This study responds to this urgency by revealing some nursing faculty care expressions, patterns, and practices that facilitate cultural competence in nursing students. The study's specific evidenced-based recommendations give nursing educators and administrators strategies they can use to initiate or extend school of nursing efforts to produce a culturally competent nursing workforce. The findings also demonstrate that application of the CCT and ethnonursing research method extends beyond clinical environments and into the study of nursing education. Future research could examine the effectiveness of using an organizing framework or creating a caring institutional culture to teach and model cultural competence. More studies are needed to examine how culture care is taught in other countries, uncover other elements that affect educators and students during the process of learning culturally competent care, and refine the best ways to incorporate culture care into nursing curricula in an evidence- and broad-based manner.

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